EXPLORING THE LIVED EXPERIENCES OF THE ADMINISTRATIVE STAFF OF A LONG-TERM CARE FACILITY: A PHENOMENOLOGICAL APPROACH

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Abstract

The process of admission of typically older residents has been greatly examined from the perspectives of the residents and their family members/caregivers. However, the viewpoint of the administrative staff directly involved in this process has been left relatively unexamined. The central focus of this study was to answer the question of: *What are the lived experiences of Long-Term Care (LTC) administrative staff working with families/caregivers during the admissions process?* A phenomenological approach was undertaken to highlight the admissions process and the associated duties of the participants, as well as the intangible and emotional experiences of the administrative staff working within the pressurized LTC system. Findings were evaluated and compared to extant literature to provide novel deductions and future research directions were highlighted accordingly.

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Table of Contents

CHAPTER 1

Introduction

Background

As defined by the Ontario Long-Term Care Association (OLTCA, 2017), long-term care (LTC) facilities are healthcare institutions that provide a variety of services on a 24-hour basis to meet both the medical and non-medical needs of LTC residents. This type of facility is synonymous with 'nursing homes' as LTC provides care to typically older residents over longer periods of time to support the management of chronic illnesses and/or disabilities (Medline Plus, 2018). This research project focused on public health LTC facilities, which are heavily subsidized by the provincial government so that the residents and/or their family members/caregivers do not pay the direct costs of living and receiving 24-hour care services (C-Care, 2016). Conversely, private LTC facilities (sometimes referred to as 'retirement homes') are funded by private investors (Medline Plus, 2018), which were excluded from this study. The main distinguishing factor between these two types of facilities is the eligibility criteria that must be met to gain admittance into a public LTC facility (C-Care, 2016; Province of Ontario, 2014). These criteria include: age 18 years or greater; possess a valid Ontario Health Insurance Program (OHIP) card; require 24-hour nursing and personal care; have care needs that require on-site supervision/monitoring to ensure safety; and have care needs that cannot be safely met in the community through community-based services or other caregiving supports.

In Ontario, the Local Health Integration Network (LHIN) is responsible for assessing the aforementioned eligibility criteria of those who potentially need to move into a LTC facility and for providing information about the availability of beds in various facilities (Province of Ontario, 2014). Navigating the assessment and admissions process into a LTC facility has been

challenging and sometimes confusing for prospective residents and/or their family members/caregivers (as reflected by the number of organizations that will be discussed shortly). Many family members/caregivers can find this process frustrating and tedious as they must collect a vast amount of information before selecting a LTC facility to admit the resident-to-be into (or, more realistically, before selecting a LTC facility to have the resident-to-be waitlisted for admittance) (examples include organizations such as Advocacy Centre for the Elderly that provide tips and traps for maneuvering the LTC admissions process; see http://www.advocacycentreelderly.org/).

To address these issues and concerns, private non-profit organizations such as *Concerned Friends* and *A Place for Mom* were established to assist the process of collecting information and comparing different LTC facilities in accordance to the provided amenities and costs, to ease the workload and reduce the burden of responsibility that would otherwise be placed on the family members (see http://www.concernedfriends.ca/understanding-long-term-care/long-term-care-guide and https://canada.aplaceformom.com). Such organizations are examples of ways in which family members/caregivers can obtain information on and/or assistance with the admissions process. Another important support system in the navigation of the admissions process into LTC for residents and family members/caregivers are the administrative staff of LTC facilities, who were the stakeholders of interest for the current study.

Past research on the topic of LTC facilities has focused predominantly on areas such as the quality of life of the residents within LTC facilities; variations in and the impacts of different types of care services provided in LTC facilities; and issues, concerns, and occupational welfare of LTC nursing and staff teams (e.g., Bloemen et al., 2015; Conner et al., 2011; Homer et al., 1990; Schiamber et al., 2012). In addition to this extensive research, the lived experiences of the

family members/caregivers of residents are also greatly examined (Armstrong, 2009; Pillemar et al., 2008; Smyer et al., 1991). More specific to the process of admission to LTC, research has also focused on the perspectives of the typically older LTC residents and their family/caregivers. However, the viewpoints of the administrative staff directly involved in this process remains largely unexamined, especially in a Canadian context.

The aim of this research project was to address this gap in literature by exploring the perspective of the administrative staff working face-to-face with typically older persons and their family members/caregivers, with particular attention given to the admissions process. Although older residents are typically more prevalent in LTC facilities, they are not limited to just older adults; therefore, experiences of the administrative staff working with potentially younger residents were not excluded. As significant stakeholders in the LTC system, this research project sought to answer the central question of: *What are the lived experiences of LTC administrative staff working with family members/caregivers during the admissions process?*

Organization of Thesis

This thesis is organized in the following way: Chapter 1 provides a brief, high-level background on the thesis topic area and the structure of this document. Chapters 2 will outline the relevant related scholarly literature(s) that frame the substantive issues at the core of this project from the perspectives of the three stakeholders involved in the process of admissions: The family members/caregiver, the residents/residents-to-be, the administrative staff. Chapter 3 will outline the phenomenological approach (methodology) and qualitative method (semi-structured interviews) employed in this study to examine the lived experiences of the participants. Following this, Chapters 4 and 5 highlight key themes that were identified from data analysis in relation to the central research question noted above. Chapter 4 will address the

admissions process pertaining to the work and experiences of the administrative staff. Chapter 5 will focus on the intangible and emotional experiences of the administrative staff as they deal with unofficial and challenging professional as well as personal duties. The final discussion and conclusion summarize and synthesize the main research findings in relation to the extant literature on the topic, acknowledge the strengths and limitations of this study and offers some ideas for future research directions.

A key terms section can be located under Appendix A to provide an easy-to-access list of commonly used terminology in this research project. The recruitment letter initially used for participant recruitment is located under Appendix B. Appendix C provides the interview guide that was utilized to explore the experiences of the administrative staff. The informed consent form provided to, and signed in agreement by the participants prior to conduction of interviews, can be located under Appendix D. Lastly, the Tri-Council Policy Statement (TCPS) certificate of the researcher is included under Appendix E.

CHAPTER 2

Review of Literature

The process of admission into a LTC facility involves three main stakeholders: The typically older resident-to-be, the family members or caregivers of the resident-to-be, and the administrative staff directly involved in admittance and transfer of the residents-to-be into the LTC facility. The experiences, perceptions, and emotions of these three stakeholders are key to understanding the impact of the admission of residents into a LTC facility on their lives and the lives of those around them. Whilst there has been extensive research conducted on factors affecting the lived experiences of the older person and their family members/caregivers in association to the admission process (as will be discussed further below), there is very limited literature studying the lived experiences of the administrative staff working face-to-face with the other stakeholder groups. In this literature review, some of the insights on the experiences of older residents-to-be, admitted residents, and their family members/caregivers is offered to highlight the gaps in and lack of literature on understanding the procedural, emotional, and lived experiences of the third group of stakeholders (i.e., administrative staff) as they work on admitting individuals into LTC facilities. This section will also highlight some of the limited literature that is available on the experiences of the administrative staff. Before delving into the examination of the literature on the topic of interest, a brief overview of available demographic data is warranted to provide the context for the overall purpose of the study.

Demographic Background

Canada is experiencing a significant and unprecedented demographic shift toward older ages as persons aged 65 years and older, commonly referred to as seniors by governmental agencies, now outnumber those aged zero to 14 years (Statistics Canada, 2015). Currently, older

adults make up 16.9% of the Canadian population and this number is expected to increase to 20.1% by 2024 (Statistics Canada, 2015; Statistics Canada, 2016). According to recent data, the Census Metropolitan Area (CMA) of Toronto demonstrates that 14.5% of its population is older than 65 years of age (Statistics Canada, 2016).

To meet the demands of an aging population, the City of Toronto (excluding the Greater Toronto Area) operates ten public LTC facilities to which prospective residents who require such levels of care may apply (City of Toronto, 2018). Through contacting the appropriate LHIN, the eligibility of the applicant will be verified, information regarding the homes and their costs will be provided, and the application process may be initiated (Province of Ontario, 2014). From this point on, the applicant (and/or their family member/caregiver, legal guardian/power of attorney) will provide the LHIN with a list of their preferred facilities and then wait for an available bed. It is important to note that although the City of Toronto operates ten LTC facilities, the LHIN will link applicants with both public and private locations (currently 36 homes in the central Toronto region) (OLTCA, 2017). Furthermore, the Ontario Long-Term Care Association (OLTCA, 2017) reported that, as of June 2017, 2,564 individuals were on the waitlist to be admitted into a LTC facility with an average time to placement of 246 days. This information, paired with the trend report of the national health expenditure database of 2017 (stating that from 2005 to 2015, the share of the health expenditure allocated to Canadians over the age of 65 years has increased from 44.3% to 46.0% as this population grew by approximately 3%), highlights that future older adults in Toronto may have an even greater level of difficulty accessing or receiving adequate healthcare services than currently observed.

As mentioned in Chapter 1, Toronto-area LTC facilities are funded by the provincial government of Ontario, which relies upon block transfers from the federal government. Central

government funding is transferred to the Ministry of Health and Long-Term Care (MOHLTC), which is then responsible for dispersing money to the appropriate healthcare bodies/networks (e.g., the Ontario Health Insurance Plan (OHIP), Local Health Integration Networks (LHINs), etc.) (Closing the Gap, 2018). Ontario has 14 LHINs that are responsible for the provision of healthcare services in accordance to the needs of the community and population to which they have been assigned (Closing the Gap, 2018). These healthcare services include long-term care homes, hospitals, community support agencies, and home and community care (Closing the Gap, 2018).

With quality of service at the forefront of concerns, communication and expression of potential complaints (urgent or non-urgent) to the MOHLTC are welcomed in order to ensure satisfactory client-focused services (Ontario, 2019). Despite efforts to ensure the highest possible standard and quality of care, critics of the LTC system, and more broadly the MOHLTC, raise issue with the insufficient government subsidies to renovate and rebuild LTC infrastructure (Goffin, 2016). Furthermore, critics claim that government subsidies do not keep up with inflation rates, cost of construction, and municipal development fees (Goffin, 2016). This is in addition to the already existing concerns over the long waitlists, and lack of available beds in LTC facilities (Born, Dhalla & Laupacis, 2011). Some reports show that approximately one in five people on the waitlist for LTC admissions have low medical/support needs, thus, are congesting the system (Born et al., 2011). While building of new LTC facilities is believed to be a possible short-term solution to the lack of service provided to older populations in need of 24-hour care, the previously mentioned subsidies significantly hinder truly addressing such issues.

Experiences of Administrative Staff and Residents-to-be

The central aim of this project was to better understand the experiences and perspectives of the administrative staff working face-to-face with typically older residents and their family members/caregivers during the process of admission into a LTC facility. Thus, a brief examination of the existing literature on the lived experiences of older LTC residents and their families/caregivers is warranted. The lived experiences of older residents of LTC homes and their family members has been greatly studied (e.g., see Azoulay et al. (2004); Azoulay et al. (2005); McDonald, Sheppard, Hitzig & Spalter (2015); Rosen, Pillemer & Lachs (2008); Schiamber et al. (2012); and Tu, Lai, Shin, Chang & Li (2012)). However, there is limited coverage of the lived experiences of the administrative staff involved in the process of admission. This is especially true for the CMA of Toronto, making this research project critical for expanding the current field of knowledge.

Administrative Staff. The limited research that focuses on the administrative staff population in the LTC context tends to study staff from a managerial perspective, with attention paid to professional conduct towards and approaches in creating an environment in which both the family members/caregivers and the older resident can engage in decision-making (Kao, Travis & Acton, 2004). An examination of literature pertaining to other members of the administrative team within the healthcare field reinforces the emphasis on studying work processes as managerial and strategic aspects of the job are highlighted (Finley, Ivanitskaya & Kennedy, 2007; German, Tyler, Darnall & Lerner, 2004; Kash, Spaulding, Johnson & Gamm, 2014). As such, the general tone of research is predominantly within the realm of organizational behaviour and healthcare management, not the phenomenological realm.

The literature surrounding administrative staff and the admissions process does not elaborate on the lived experiences of this population, and, at best, only presents their general work responsibilities (which lacks a clarification and elaboration of the actual experiences of the staff) while focusing on other staff members of LTC facilities. A broad examination of the past studies concerning administrative staff within a healthcare environment (e.g., nurses, physicians, and administrative staff) provides reports of a high level of occupational stress (Tsai & Liu, 2012; Weinberg & Creed, 2000). This outcome may be a result of a combination of stressors outside of work and at work (e.g., long working hours, heavy workloads, time-related pressures, low levels of decision-making authority, high demands, and lack of social support) that can cause anxiety and depressive symptoms and disorders (Tsai & Liu, 2012; Weinberg & Creed, 2000). Solutions to stress-related symptoms and disorders typically involve the promotion of individual treatments or interventions in the sense of healthy lifestyle behaviours paired with organizational programs that attempt to reduce workplace stress (Tsai & Liu, 2012; Weinberg & Creed, 2000).

Administrative staff are believed to be considerate of the ethnic and cultural backgrounds of the individuals as they are responsible for presenting available options and working with family members/caregivers to ensure that the relocation process causes as little stress as possible (Kao et al., 2004). As family members/caregivers and residents-to-be go through the process of admission and moving into the facility, gaps are believed to be present between what the family members/caregivers, residents-to-be, and the nursing staff expect from the quality of services that will be provided at the LTC home (Duffy, Duffy & Kilbourne, 2001). At this point, the administrative staff who works with the family seeks to bridge the supposed gaps between differences in expectations and miscommunications among nursing staff of the LTC home and

the family members/caregivers of the older resident (Duffy et al., 2001; Pillemer, Hegeman, Albright, Henderson & Morrow-Howell, 1998).

Literature examining the experiences of healthcare administrative staff in non-LTC context indicates that administrative leaders who exercise open communication and greater teamwork achieve better organizational performance than those who lack leadership, communication, and teamwork skills (Vogelsmeier & Scott-Cawiezell, 2011). Furthermore, in addition to possession of helpful skill attributes, understanding perspectives of the different types of administrative staff, along with other healthcare professionals, was highlighted as critical for all efforts towards improvement of quality of service (Kirchner et al., 2012). Considering that each professional within the healthcare system has their own unique role and view on the duties of others, involvement of, and examination of different stakeholders, was labelled as the most significant contributing factor for promoting quality improvement implementation within a healthcare system (Kirchner et al., 2012). In addition, to gauge the significance of studying the involvement of administrative staff, one study showed that patients or clients receiving psycho-therapeutic treatment, rated their treatment outcomes more positively if they had positive interactions with the administrative staff of the clinic (Sandage et al., 2017). This shows that understanding the experiences of the administrative staff is crucial for improving the quality of service at both individual and systematic levels.

Residents-to-be. The process of admission can potentially induce high levels of stress among residents-to-be and new residents of LTC facilities as decision-making processes highlight their significant reliance on their family members as they may be cognitively debilitated (Duffy et al., 2001). In fact, there is often minimal participation and inclusion of the older resident-to-be on making decisions to relocate into a LTC facility (Fraher & Coffey, 2011).

However, experiences of stress and anxiety are not restricted to physical relocation as many also experience stress during the process of having to dispose of their belongings to move into an institution (Duffy et al., 2001). One of the reported responsibilities of the administrative staff is to gauge this level of discomfort and work to relieve any worries present by designing and maintaining an appropriate service system (Bauer, 1996; Duffy et al., 2001). It has been claimed that identifying the source of stress, and actively addressing that concern can be significantly beneficial in helping to ease the transition from a home environment into a LTC facility (Bauer, 1996). The viewpoint of the administrative staff on their experiences in terms of such issues has not been specifically studied.

To address the stressful impact of moving into a LTC facility, researchers have identified and examined a disorder known as the Relocation Stress Syndrome (RSS) among residents-to-be and new residents of LTC facilities (e.g., Manion and Rantz (1995); Melrose (2004); Melrose (2013)). RSS, which was previously referred to as "transfer stress", "transfer anxiety", "translocation syndrome", and "transfer shock" is an accepted diagnosis approved by the North American Nursing Diagnosis Association (NANDA), which is a nursing diagnostic tool that describes "human response to actual or potential health problems and life processes" and is complementary to a medical diagnosis (NANDA International, 2018) (Manion & Rantz, 1995, p. 108; Melrose, 2004, p. 15; Melrose, 2013). RSS is defined as "physiological and/or psychosocial disturbances as a result of transfer from one environment to another" (Manion & Rantz, 1995, p. 108) and is characterized by symptoms such as anxiety, hopelessness, depression, confusion, loneliness, sleep disturbances, etc. (Melrose, 2004; Walker, Curry & Hogstel, 2007).

As the transition to a LTC facility is identified as the most significant relocation for older populations, there is an abundance of older persons' pre- and post-placement experiences and the

psychological effects on both the resident and their family members/caregivers (Ellis, 2010; Lee, Woo & Mackenzie, 2002). This reinforces the critical need for exploring and understanding the experiences of all involved parties, which is inclusive of the administrative staff that work with family members/caregivers and residents-to-be, during the admissions process.

Experiences of Family Members/Caregivers

In contrast to the (lacking) evidence of the administrative staff during the LTC admissions process, the experiences of family members/caregivers placing their family members into a LTC facility are greatly examined. Most of the times, the ultimate decision of having an older family member enter a LTC facility is considered to be a last resort for family members/caregivers as older persons tend to prefer living at home (Cheek & Ballantyne, 2001). The most common emotions experienced by family members during this process are the feelings of guilt, helplessness, stress, and relief (Cheek & Ballantyne, 2001; Kellett, 2001; Nolan & Dellasega, 2001; Pearson, Nay & Taylor, 2004). Ultimately, the inability to cope with taking care of an older person, the inability of the older person to cope alone, the lack of support from other family members, and the demanding health needs of the older individual outweigh the desire for or ability to provide unpaid care for a parent or family member (Buhr, Kuchibhatla & Clipp, 2006; Cheek & Ballantyne, 2001; Davies & Nolan, 2004; Dellasega, Mastrian & Weinert, 1995; Pearson et al., 2004; Ryan & Scullion, 2000).

Many family members have described that their impressions and service-quality expectations of LTC facilities vary from favourable to unfavourable and, in many instances, was different from their admitted family members (Bauer, 1996; Pearson et al., 2004). This was said to be due to varying experiences during both the day of admission and after the completion of admission: “Some of the questions that they have to ask, you’re emotionally not ready to deal

with. Like, 'what funeral parlour?' and you know, arrangements for his death," "the first day when you talk to them, they're trying to impress you. They don't live up to that next stage […] sort of like they don't give you any time" (Pearson et al., 2004, p. 89). However, while many family members/caregivers can experience relief from placing their family member under professional care, others express that the admissions process was distressing as they were unprepared to tackle the legal responsibilities and arrangements that had to be made on behalf of, and for the future of, their family member (Pearson et al., 2004). Statements such as "I don't have any other choice" (Lundh, Sandberg & Nolan, 2001, p. 1182), "I really feel I've let him down" (Nolan & Dellasega, 2000, p. 759), and "It's not the same as him being at home" (Nolan & Dellasega, 2001, p. 723) are commonly mentioned in qualitative studies that examine the feelings experienced by family members/caregivers on having to move their older family members into LTC facilities. Other experiences on moving an older family member out of their/one's own home and into an institution generates feelings of unpreparedness as well as the perceived or actual lack of emotional support from the staff of LTC facilities (Eika, Espnes, Soderhamn & Hvalvik, 2013; Reuss, Dupuis & Whitfield, 2005).

Comparatively, the older residents tend to be, or are made to be, passive in the search and selection process of a LTC facility prior to their admission as many instances of seeking residency come from a cognitively debilitating health crisis (Cheek & Ballantyne, 2014). This places a great amount of pressure and even burden on their family members/caregivers as they become solely responsible for all decision-making processes (Cheek & Ballantyne, 2014; Davies & Nolan, 2004; Pearson et al., 2004). This potentially leads to uninformed or hasty decision-making in accepting a placement at a LTC facility as family members/caregivers have to quickly dispose of or relocate their family members' belongings into the new home (Pearson et al.,

2004). The impact of such circumstances could potentially affect or complicate the works of the administrative staff that are working with family members/caregivers during admissions, but have been left unexamined.

Admissions Process. In relation to the research on experiences of family members/caregivers, the process of admitting a family member into a LTC facility and the admissions procedure continues to remain a largely unexplored area despite individuals' expression of significantly contrasting opinions and experiences with the process (Lundh, Sandberg & Nolan, 2001; Sandberg, Lundh & Nolan, 2001). In spite of the experiences of the family members during admission (whether positive or negative overall), family members'/caregivers' involvement with and within the LTC facility continues to remain a major component of unpaid/informal complementary care provided within institutionalized settings (Friedemann, Montgomery, Rice & Farrell, 1999; Gaugler, 2003; Jacob, 1998; Kellett, 2001; Ryan & Scullion, 2001; York & Calsyn, 1997). While the process of admitting a family member into a LTC facility is said to be emotionally straining and stressful, it is believed that stress decreases over time (Levine, Halper, Peist & Gould, 2010; Nolan & Dellasega, 2001; Ryan, 2002). More specifically, the temporal nature of coping is demonstrated by studies that divide the experiences of family members/caregivers into stages such as: "the waiting begins" (p. 33) and "after placement" (p. 35) (see Strang, Koop, Dupuis-Blanchard, Nordstrom & Thompson, 2006); "making the best of it", "making the move", and "making it better" (see Davies & Nolan, 2003, p. 429); and "pre-move" and "post-move" (see Sussman & Dupuis, 2012, p. 397).

The functional health conditions of a resident-to-be determine the starting point for the experiences of a family member/caregiver: whether they are accepting of the need for, and the timing of, having a family member move into a LTC during the 'pre-move' stage, and their

perceptions of the LTC facility as an appropriate place of residence for their family member during the 'post-move' stage (Sussman & Dupuis, 2012). The theme of 'crisis as initiator' is typically observed in family members/caregivers during the waiting period before having a family member move into a LTC facility, while post-move familial experiences can be described by themes of wanting to develop stronger relationships (Strang et al., 2006). Davies and Nolan (2003) state that experiences of family members/caregivers can be described by understanding if they were "under pressure" or not, "supported" emotionally or not, "in control of events" or not, "working together" or "working alone", and "in the know" or "working in the dark" (p. 429). It was also stated that the negative experiences of these elements could be greatly alleviated and positively influenced by the support of LTC staff (Davies & Nolan, 2003). Furthermore, while decisions to have a family member enter a LTC facility are typically hurried due to the nature of admissions systems, it is important to recognize admissions as "part of the process" (p. 443) and "a new beginning" (p. 444) as opposed to "reaching the end" (p. 444) to provision of care by family members/caregivers (Dellasega & Nolan, 1997). Considering the multi-staged and complex nature of the experiences of family members/caregivers during the process of admissions, the lack of literature examining the experiences of the administrative staff working with this population is concerning.

Focus of Study

As highlighted above, there is notably more literature discussing the lived experiences of typically older residents or residents-to-be and their family members/caregivers than the administrative staff despite this latter group being vitally important stakeholders in the admission process. Thus, the focus of this research project was to explore the perspectives of the administrative staff working face-to-face with the residents-to-be and their family

members/caregivers, with particular attention to the admissions process. As significant stakeholders of the phenomenon of admittance into LTC facilities, this research project sought to answer: *What are the lived experiences of LTC administrative staff working with families/caregivers during the admissions process?* The following chapter will outline the methodology and methods that were employed in this study to answer this research question.

CHAPTER 3

Methodology and Methods

This study employed qualitative methods, specifically semi-structured interviews, to examine the lived experiences of the administrative staff working with family members/caregivers and residents-to-be during the admission process into the LTC facility. This chapter will discuss the data collection and analysis methods employed in this study, and provide some of my personal reflections and experiences as a researcher during the conduction of this research project.

Adopting a phenomenological research orientation, this research project sought to identify and understand significant themes associated with the experiences of the participants. Philosophically, phenomenology is centered around the study of the human existence and peoples' perceptions and understanding of the world (Larkin & Thompson, 2012; Sloan & Bowe, 2014; Sokolowski, 2000; Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013). This philosophy is typically described in two historical phases, transcendental and hermeneutic (Larkin & Thompson, 2012; Sloan & Bowe, 2014; Tuohy et al., 2013). Transcendental phenomenology (founded by Husserl in 1900/1901) refers to the identification and suspension of personal assumptions, culture, and context, initially created to get at the universal essence of a phenomenon (via bracketing off everything else) (Larkin & Thompson, 2012; Sokolowski, 2000). Husserl's successors, Heidegger and Mearleu-Ponty, later stated that transcendental phenomenology is not possible as human beings are always situated within the world and involved in relationships with others—thereby creating hermeneutic phenomenology (Larkin & Thompson, 2012). Hermeneutic phenomenology, also known as interpretive phenomenology, posits that, although experiences may be descriptive in nature, their implantation is interpretive

in the sense that a researcher is required to understand the data while identifying key thematic findings through an intersubjective process (Sloan & Bowe, 2014).

This research project used an interpretive phenomenological approach and, more specifically, employed Schutz's (1970) social phenomenology framework. This framework focuses on the impact of social relationships on the participants' daily life that results in, or at least contributes to, the manifestation of logical meanings of findings (Fereday & Muir-Cochrane, 2006). Further, Schutz's (1970) approach to phenomenology focuses on examining life from various perspectives by: first, analyzing the natural attitude of an individual operating within the world (i.e., the external conditions that influence their actions as they deal with objects, and their intentions as they deal/cooperate with others); second, by assessing the major factors influencing the circumstances in which an individual is situated (i.e., limitations, conditions, or opportunities); and third, by evaluating the means by which an individual orients themselves within life as a result of their "store of experience" or "stock of knowledge on hand" (Schutz, 1970, p. 15). This three-fold consideration leads to a realistic and objective representation of an individual's understanding of a phenomenon as it places a great amount of emphasis on the significance and relevancy of past experiences and knowledge of the individual of interest (Schutz, 1970). This approach was employed through careful curation of the interview guide to prod participants to reflect on their social experiences during the LTC admissions process. It was also used during data analysis and interpretation to understand the impact of social experiences on the lives of the administrative staff.

Research Setting

Six different facilities were enlisted for the completion of this research project. Considering that there are only 10 LTC facilities within the City of Toronto, the names of these

facilities will not be disclosed to maintain the anonymity and confidentiality of the facilities and research participants. Initially, I started my participant recruitment procedure by visiting four different LTC facilities. However, upon providing my letter of recruitment, one administrator informed me of the need for an additional ethics and research approval (obtained from the Ethics/Research Committee of Long-Term Care Homes & Services Division herein referred to as simply Ethics/Research Committee). This second approval was a mandated requirement despite possession of the institutional ethics approval from York University and the low-risk nature of the research project. As such, I immediately completed and submitted the necessary forms and documents to have my project processed in time for the next ethics committee meeting. Due to other unforeseen complications, I received approval in approximately two months instead of the original two-week time period that was expected. While no research and ethics amendments were required, this forced changes to the participant recruitment procedure, data collection timeline, and the transcription procedure. I managed to complete seven interviews in five days (on two days I completed two interviews) to meet the deadlines for completing my project on time. The consequences of an additional ethics procedure will be discussed in greater detail in the following sections of this chapter. However, it is crucial to highlight that procedural changes did not negatively impact the quality of the data analysis or the discussion of findings.

Participant Recruitment

The seven participants for this research project included the administrative staff of LTC facilities, operationally defined as the individuals responsible for the coordination of the resident-to-be from their pre-admission residencies into a LTC facility setting (Kao et al., 2004). Majority of the participants had many years of experience either with working in administrative positions or for the City of Toronto (ranging from four years to 30+ years of experience).

Participants were initially to be recruited using a purposive sample selection by reaching out to a LTC facility within the City of Toronto and providing a study information and recruitment letter (Appendix B) regarding the research project. In addition, a snowball technique was to also be initially used to facilitate the recruitment process as I am currently a volunteer at a Toronto LTC facility. These recruitment approaches were approved by York University's Research Ethics Board prior to data collection. However, as noted above, due to unforeseeable procedural complications regarding the ethics requirement set by the City of Toronto, recruitment through these channels was placed on hold until second approval was granted and ultimately expedited to meet the time constraints of the project (discussed in greater detail under the 'Personal Experiences' section below). Following ethics approval through the LTC facilities, an administrator of a LTC facility personally reached out to administrators of other locations to identify facilities with administrative staff that had agreed to participate in my research project. After being informed of the different facilities by the gatekeeper administrator, I contacted the administrators of each home via email to receive the contact information of the appropriate participant within that facility. It is crucial to highlight that the participants had the right to refuse or withdraw their participation without facing occupational consequences, and that the administrative staff associated with the LTC locations that I had been provided had already agreed to participate in my project. Thus, there was no risk of, or perception of, coercion. Once contact was made, I sent study information and recruitment information to the appropriate administrative staff by either email or phone.

Data Collection

The interviews were conducted at the LTC facilities of the participants. A semi-structured interview guide (see Appendix C) was used in this study as this format allowed for some

measure of consistency across the interviews in terms of topics to be raised by the interviewer with the interviewee, while also allowing flexibility and flow within the guided conversation between the interviewer and interviewees. The open-ended nature of the questions allowed for myself as the interviewer to follow topical trajectories and seek clarification (Brinkmann, 2014; Galletta, 2013). Participants also had the opportunity to elaborate and emphasize themes that they felt were most meaningful during the interviews (Galletta, 2013).

The duration of the interviews ranged between 45 to 80 minutes (with the average interview lasting 60 minutes), and all participants gave me permission to follow up with them following the interviews, if needed, to seek clarification or ask follow-up questions (was not required). All interviews occurred in-person with the interviewee having the option to choose the location (e.g., the LTC facility, a public space in their local community, or York University). All participants selected to have the interview occur at their respective LTC facilities. The interviews were audio-recorded and complemented with field notes that I took during its conduction. One participant declined to have their interview audio-recorded but agreed to allow me to take notes of our conversation during the interview. The participants of the research project were referred to by pseudonyms in the form of initials. The first 14 letters of the alphabet were randomly assigned to the seven participants to ensure gender and cultural anonymity.

Due to the delay in receiving ethics approval from the Ethics/Research Committee of the Toronto Long-Term Care Homes, non-verbatim transcription of the audio-recorded interviews was used. This type of transcription is not fully representative of all words of the participants as it excludes sound fillers, false starts, and corrects for grammatical errors to be more reader-friendly (Corners, 2015; Kumar, 2019). While non-verbatim transcripts provide a more concise and ‘clean’ read, some argue that verbatim transcripts capture the emotional state of participants

more fulsomely (Vinita, 2018). Judging the nature of this research project and the openness in discussion of personal experiences and feelings, usage of a non-verbatim transcript is not believed to be a debilitating factor in the effective analysis of emergent themes.

Before transcribing the interviews, all audio recordings were listened to multiple times, and notes were taken on words, statements, and passages that resonated with me as significant to the research question of the project: *What are the lived experiences of LTC administrative staff working with family members/caregivers during the admissions process?* My own notes from the interviews supplemented this process.

Following the multiple listening sessions, I engaged in non-verbatim transcription of each audio-recorded interview. I carefully typed out a large majority of the words and sentences of the participants. Due to my immersion in the extant literature on this topic, the immediacy of the interviews themselves (i.e., the fact that they had just happened prior to the transcription), as well as, my own personal experiences in the LTC system, I was vigilant in identifying significant words, sentences, passages, and exchanges that were included in my transcripts. Furthermore, the fact that the audio recordings were listened to multiple times and compared with notes, allowed the transcribed interviews to be highly reflective of the majority of the content provided by each participant. After the transcripts were completed, I re-listened the audio recordings to ensure that the passages were accurately presented. Due to the small sample size and nature of this project, the findings of this study may not be transferrable to other healthcare or social service settings, nor are the findings robust enough to support recommendations to enact change at systematic levels. However, thematic saturation was reached and may account for transferability and potential change at the individual/interpersonal level.

Data Analysis

Following this process, the interview transcripts were then read and re-read, and free codes (basic and preliminary form of analysis to provide general ideas about the overall data (Yi, 2018)) were added. Free coding enabled me to highlight preliminary interpretations of the data while identifying personal preconceptions and biases (Larkin & Thompson, 2012). This process allowed me to remain reflexive throughout the research project (Larkin & Thompson, 2012). However, this type of coding had already initiated prior to the transcription process as I had to listen to the audio recordings of interviews and compare notes before initiating the official transcription of the data. Despite verbatim transcription being known as the golden standard for transcription, multiple listening to the audio recordings while note-taking allowed me to stay close to the words of the participants.

Upon completion of free coding, I created open codes (labelling concepts and developing categories based on the data (Corbin & Strauss, 2014)) by conducting a systematic line-by-line coding while being mindful of the initially identified free codes. This data-driven inductive approach to coding ensured rigor within the qualitative analytical methods and encouraged me to "capture the qualitative richness of the phenomenon" (Boyatzis, 1998, p. X; Fereday & Muir-Cochrane, 2006).

After creating the open codes, I carefully read over the data and each code in relation to one another to identify the emergent themes (Fereday & Muir-Cochrane, 2006; Larkin & Thompson, 2012). Boyatzis (1998) defines themes as "a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon" (p. 161). As such, the careful conduction of this step was of utmost importance for this study. It is crucial to note that while this procedure seems systematically

linear due to its step-by-step description, there was a great level of overlap between the systematic coding process and maintenance of reflexivity via repeated referencing to the initial free codes. This reinforced rigor and represented the phenomenological approach of the research project. The research question and the phenomenological approach (more specifically, social phenomenology) were constantly referenced during the analysis of transcriptions to observe and identify relevant themes to the research project.

After the identification of emergent themes, specific quotes that were used were returned to the participants to provide them with the opportunity to review and provide information, if necessary. This technique afforded me the opportunity to 'check in' my study participants and for them to communicate to me if my transcriptions were accurate and meaningful to them and to provide further information if they felt it necessary. This member checking enhanced the trustworthiness of the research project as the participants were provided with a voice to ensure appropriate transfer and analysis of their lived experiences. In efforts to ensure clarity of reading, transcribed quotes from the participants were presented after being lightly edited (i.e., sound fillers such as 'ums' and 'ohs' were excluded for the purposes of providing a coherent and clean transcription) (Salongo, 2018).

Ethics Approval, Confidentiality and Informed Consent

Every effort was taken to ensure that this study followed the regulations and policies set out under the York University Graduate Student Human Participants Research Protocol. Participant recruitment did not start until ethics approval was received from York University. When a second ethics approval was required from the Ethics/Research Committee of the Toronto Long-Term Care Homes, participant recruitment was paused until an approval was received. All participants were required to sign an Informed Consent Form (Appendix D), which provided the

details of the purpose of the research, what was required from the participants, anticipated risks, direct and indirect benefits, ensured privacy and confidentiality of participants, and provided procedures for follow-up inquiries or withdrawing from the study. All interviews were conducted in person, at which point the consent forms were signed and a copy was provided to the participant. The study was considered to be low-risk (meaning that the probability of possible harm occurring through participation was not greater than experiencing harm in the aspects of the participants' everyday life relevant to the research (York University Graduate Studies, n.d.)) and problems were not anticipated to occur from the interview process. However, in the event that problems were to arise (which in this case, they did not), they would have been brought to the attention of my supervisor, Dr. Parissa Safai so that the appropriate actions would be taken.

All transcripts were anonymized and remained (and will continue to remain) confidential—only shared with my supervisor when necessary. Participants' identities and their respective LTC facility continues to remain anonymized via usage of pseudonyms in transcriptions. Further, all transcripts and notes are stored on my password-protected computer. The audio recordings, which were also stored on my password-protected computer, have been deleted in accordance to the signed informed consent agreement with the participants.

Researcher Reflections and Experiences

Prior to this research project, my experiences as a qualitative researcher were restricted to a project completed in a graduate-level qualitative research course. Having had the opportunity to engage in a semi-structured interview in that course, I was aware that the interview would be relatively comfortable as it is much like a guided conversation (Berg, 2009). Due to this bit of familiarity with the interview process, the conduction of the actual interviews were highly enjoyable for me as they provided me with the opportunity to engage with the participants and

learn about their perspectives on the admissions process at LTC facilities, as well as their experiences with family members/caregivers and residents-to-be. I did struggle initially as I was too keen on the words of participants to directly address my research question and address the aim of my project. The great amount of emphasis and concern for maintaining faith to the words and sentences of the participants, made completion of my analysis in a timely manner a more stressful experience. However, I eventually managed to identify significant themes from the experiences of the administrative staff.

As noted above, the steps before scheduling and completing the interviews were not as stress-free as initially expected. After being notified of the need for an additional research and ethics approval, I immediately submitted all necessary documents and reached out to multiple sources (an administrator, Toronto Public Health Research Ethics Board (via a general email contact), LTC Ethics/Research Committee (via a general email contact), as well as a LTC Ethics/Research Committee member) to discuss the urgency of processing and reviewing my research project. Due to the busy schedule of others and certain complications, the initial response time of two weeks transformed into two months, placing an incredible amount of stress on myself and leading to time-related changes to the progress of my project. One significant change was the participant recruitment process as I had to depend on gatekeepers to assist my project to move forward.

Reliance on Gatekeepers. The requirement of an additional ethics approval and the drastically altered timeline prevented enactment of my initial participant recruitment procedure. This meant that I had to rely on another individual to assist with guiding my research project forward. Much like depending on an administrator to form a line of communication between myself and the research committee, I had to rely on an administrator to get in contact with the

different LTC facilities and recruit participants on my behalf. Considering that this was the only possibility with regards to the strict timeline, I experienced the recruitment procedure as a fully virtual process. After being informed of a list of LTC facilities interested in participating in my research project, I had to get in contact with another line of gatekeepers (the administrator of each facility) to retrieve the contact information of the appropriate participant. Nonetheless, while this process turned out to be incredibly efficient (allowing me to arrange for seven consecutive interviews that occurred on five business days), it did remove from my responsibilities as a researcher and create an impersonal experience.

On the other hand, one important observation was the interactions and exchanges that I had with the administrators of the different LTC facilities. All of these gatekeepers were incredibly helpful in assisting and ensuring that the process of participant recruitment occurred as quickly as possible. Additional credit must be attributed to the initial administrator that was responsible for identifying and organizing the different LTC facilities that were interested in participating. Without the efforts of this individuals, the recruitment of a sufficient number of participants in time for the completion of this project would not have been possible.

My experiences at the different LTC facility research settings can only be described as wonderful. Every staff member and resident that I encountered during my visit was pleasant. The administrative staff were all very friendly as I was introduced into a positive environment and even offered food and beverages. I am incredibly grateful of the participants of my research project for their hospitality and for sharing their personal experiences and professional perspectives.

Insider Status. As a current volunteer of a LTC facility (not included in this research project), I had to substantiate that my involvement within the LTC community would not

interfere with my work as a researcher. With regards to ethical considerations, I can state with full certainty that there was no conflict of interest or role at any point during the completion of this research project. One reason for this was the fact that I had no personal ties or relationships with any of the participants of this project. Another reason would be the fact that my responsibilities with a LTC facility are purely directed towards providing services to the residents and their family members/caregivers. At this point in time, it is important to mention that my interactions and relationships with the family members/caregivers and the residents of a LTC facility were incredibly informative of the types of issues that may be experienced by these populations. While the family members/caregivers were not the participants of this research project, much of their experiences were topics of discussion that were brought up as impactful and significant to the experiences of the administrative staff. This factor became incredibly helpful after the changes in the timeline as it assisted me with performing verbatim transcription and easily identifying significant themes and ideas to include in my non-verbatim selective transcripts. Furthermore, my involvement as a volunteer quickly became a topic of interest for many of the participants as it allowed me to develop a more meaningful relationship during the discussion of certain experiences and topics.

CHAPTER 4

The Admissions Process

Given the central research question of this project, it is important to first present what the admissions process entails from the perspective of the LTC administrative staff. This chapter offers an outline of the admissions process as described by study participants, with specific attention paid to the interactions between the administrative staff and the family members/caregivers of the resident-to-be. In so doing, a number of the complexities associated with maneuvering the admissions process in the LTC system, including the impact of such complexities on the social interactions between the administrative staff and the family members/caregivers of the resident-to-be, are highlighted.

Administrative Staff as Managers

As will be discussed later in this chapter, the concept of teamwork is incredibly significant in the division of tasks and duties in the LTC facilities studied in this project. Due to this factor, it is important to note that the title of administrative staff is not limited to any particular job position. While the duties of the admission of a resident-to-be may be applied to the position of an admissions clerk, other administrative positions may also tackle the responsibilities associated with admission into a LTC facility.

As noted in Chapter 1 (Introduction), family members/caregivers and the resident-to-be have to apply for a potential placement at a LTC facility through the LHIN (Local Health Integration Network). Typically, this begins with an online application as the LTC admissions process is predominantly a virtual procedure. As such, family members/caregivers go through multiple steps online before finally coming face-to-face with the administrative staff at a LTC facility. All of the study participants mentioned the involvement of coordinators working on case

files of the residents-to-be during admission through the LHIN as a form of first point-of-contact in the admissions process. Once a bed/room becomes available at a LTC facility, the administrative staff of the LTC facility are responsible for informing the LHIN. An individual from their waitlist will then be assigned as a potential resident, and the administrative staff will be notified by the LHIN coordinator to examine the applicant's file. If an offer is made, the resident-to-be, or in most cases, the family members/caregivers (i.e., the power of attorney) have 24 hours to accept the offer to move in. If rejected for a placement within the particular facility, they will continue to remain on the waitlist for moving into a LTC facility. If a room is accepted, the family members/caregivers or the cognisant resident-to-be will sign the admission agreement, move in, and initiate the week-long process of nursing examinations/meeting with the different teams at the LTC facility. AB mentioned:

> *There's always a coordinator that works in the hospital, so the client can either be in a hospital, and they send the referral directly from the hospital into the website, or it's from the community, and basically, they have remote access and upload all the information*.

As described by AB, applications to a LTC facility can either come from individuals in the community or from a hospital on behalf of an individual and/or their family. The coordinator that is responsible for managing the application of the resident-to-be will inquire about the required demographic and health information for the LHIN (including the medical examination results) from the applicant and then, once satisfied that all the information is in place and up-to-date, upload everything to the LHIN database. CD (who declined to be audio-recorded) stated that, "*during this stage of the application process, each applicant can have a choice of up to five homes to which they can apply. Upon completion of their file, the LHIN coordinator will reach*

out to the coordinators of each home and inform them of a new applicant. The coordinator of each LTC facility will then get in touch with the administrative staff of the facility via email to inform them to log on to the LHIN portal system in order to view and initiate the application process." AB explained:

> *I would get an email saying, basically, I have a new file, and that's when I would log into the referral site and I would see the newest client in my dashboard. I would basically log that in my excel sheet 'cause I keep track of all the clients that have come in. That way I can manage which file is still outstanding, which one has the team approved or rejected, or deferred for more information. So, that's when I would get involved. Other than that, then my role would be other duties that are assigned to me that I have to follow up on.*

This highlights the managerial nature of the work of administrative staff as they are responsible for managing and organizing information, keeping records of residents-to-be, as well as processing approvals and rejections. Similarly, EF expands on the coordinated admissions procedure:

> *LHIN provides us an applicant list through their software. We have to go in and provide that list to the administrator of the home where then it is reviewed to make sure that, physiologically and cognitively, the individual is suitable for our facility. So, she would look at the various criteria: behavioural, medical history. Once that is approved, I would go back into the system and provide the 'okay' or 'rejection' to the LHIN to say whether that individual has been accepted to our waitlist or if there's a rejection. Then, usually* [name of a colleague] *will write a follow-up rejection letter which is provided to the LHIN and the ministry and to the families that is required. That is the initial process. Once the individuals are in the waiting list—and it is an extensive waiting list with more*

> *than 500 individuals at the moment—as beds become available, and it's usually one of two ways: a discharge or death, we provide the information to the ministry, to the LHIN. They will provide someone that they think is suitable. We again review because in the meantime they might have been on the waitlist for months or years to see if there have been changes in their behaviour, cognitive impairment, whatever it may be, to see if they're still suitable for that particular unit.* […] *A lot of cases it's fine, but sometimes we reject because they might not be suitable for the unit 'cause they're wandering or exit-seeking or they're more resistive to care. So, we would have to send the LHIN a letter or message to say, "no, not for this particular room at this particular time".*

Every participant mirrored a variation of this statement as their initial responsibility for starting the admissions process at their LTC facility. Much like AB's statement, the management of information and assortment of data to provide to the administrators and other staff members is a key component of the duties of the administrative staff. Their interactions with the other staff members portray a complex network of many individuals as they act as the liaisons between the LTC workers and the LHIN coordinators (explored more extensively in upcoming sections). Furthermore, this managerial atmosphere is also illustrated by the fast-paced nature of communicating empty beds to the LHIN—with beds being representative of available room for relocation of new residents (i.e., the customers), much like a hotel setting in which customer service is of utmost importance.

Following the theme of administrative staff as managerial figures within their duties, the bureaucratic nature of the admissions process becomes a significant reality. Between the criteria set out by the LHIN, and the resources available at the LTC facility, much of the admissions process becomes equated to meeting the requirements of a checklist. Considering that the waitlist

for admission into a LTC facility is based on the level of urgency and need for 24-hour medical and non-medical care, this checklist highlights the discrepancies between what is expected and what can be provided by the LTC facilities. EF explains this by stating:

> *The policy at the LHIN is when somebody comes up or is suitable now for a new bed that's opened up, the information has to be fairly current, three months, that's their criteria. So, let's say we had an applicant of six, eight months ago, the dementia has developed so cognitively they might be, I don't know if it's a good choice of words, impaired, or if they're having more issues so now they're exit-seeking, they're more resistive to care. Also, physiologically, they might not be able to ambulate, they can't walk anymore, or they need assistance of two people, so they're resistive. They need extra care. So, if they require an hour to two hours a day for the whole day, we do not have the staff. Our ratio of our PSWs* [Personal Support Workers: Front-line healthcare professionals who provide care to patients/residents] *to client, one to ten, that might be prohibitive on certain units. So, in this case, especially if they're now quite resistive or the behaviours are such that they're not being managed at the moment, we might refuse it at that time until we can see from the medical or behavioural paperwork that they're fairly stable. Because if someone is quite resistive, and it does happen, even it happens in the house, it becomes an issue* […] *It's just so tight as far as resources for staff.*

As the administrative staff and the other staff members involved in the process of accepting or rejecting potential residents into the LTC facility collaborate on decision-making, the bureaucracy of managing a LTC facility and its admissions process becomes very clear. Every physical, cognitive, and behavioural assessment is carefully analyzed to gauge the likelihood of the residents-to-be's integration into the LTC facility's environment. The administrative staff

also extend their assessment by incorporating the limits and capabilities of the other staff members within the LTC facility prior to providing an ultimate decision. CD (and a few other participants) mentioned that an obstacle to this assessment is when the information provided by the LHIN is inaccurate in the sense that cognitive and behavioural assessments are not fully presented. This challenge to the work of the administrative staff reinforces the potentially conflicting nature of the bureaucracy of the LHIN against that of the LTC facilities. The bureaucratic aim of the LHIN is to get residents-to-be placed into LTC facilities as fast as possible, while the aim of the LTC facility is to ensure that adequate care and safety can be provided to all residents. The passage above also highlights the constant need for maintaining accurate and regularly updated information to meet the strict criteria outlined by the LHIN. Regardless of the great desire of the administrative staff to be as helpful as possible, withholding information drastically slows the process of admission and induces greater need for back-and-forth communication with the LHIN.

Administrative Staff as Team Workers

To operate the admissions system of a LTC facility, the administrative staff have to coordinate the involvement of many other staff members. As mentioned above, the administrative staff act as liaisons between the LHIN and the rest of the staff members involved in the admission process (i.e., administrators, managers of different staff teams, and any other member involved in the process of admission and decision-making). They retrieve information from the LHIN, forward information to the rest of the admissions team, and return responses and address questions back to the LHIN. In the event of an acceptance of a resident-to-be, this coordination with other staff members expands to include other individuals and teams responsible for providing services to and taking care of residents. As such, the development of

positive relationships and effective communication skills and strategies are crucial for the successful completion of the admissions process. EF mentions the involvement of other staff members at the LTC facility during the collaborative process of coordinating the admissions process:

> *I really get involved when we have a bed available. I am the one who informs the LHIN that a room is available, what type of room, the care level, if it's secure or not, semi, basic, or private, whatever it may be, and they will give me a suitable candidate. We will then review, and at this time, review quite thoroughly to make sure that the behaviours and the care level is suitable to the bed that has been presented. Once that has been approved, I then let the LHIN know, we try to coordinate if everything is fine, if all the information is up-to-date. Sometimes prior to approving, between us and the LHIN, we will ask for additional information. So, if there are issues of behaviour, we might ask for a more current behavioural. If there's been changes, if the medical behaviour note states that there have been some occurrences in the last month, and that there's agitation and that they're sundowning and walking around room to room at two in the morning, and the behaviour was done, let's say, six weeks ago, we might ask for a more current progress note to know if they're still suitable. Also, if there's medication changes, so that we're ready. We have a BSO* [Behavioural Supports Ontario: A support team present to enhance the healthcare services of residents, and their family members/caregivers in relation to behavioural and neurological conditions] *team, behavioural support team, in the house, sometimes they have to be notified if there are behaviours and if they're borderline. The pressure is on us to take that individual.*

A few important factors highlighted within this passage include the coordination between the different administrative and LTC staff as they communicate during the admissions process, and the pressure from the LHIN system to accept applicants into LTC facilities once a bed is available (discussed more extensively later in this chapter). Within this passage, the BSO team was only one example of the staff members outside of the admissions system that the administrative staff would have to coordinate with. While the level of involvement of the administrative staff may not extend to every staff member, the provision of the required information to the team managers/leaders is necessary for the completion of an admission process. Maintenance of the efficiency of the admissions process demands a great level of assessment and communication throughout the LTC facility.

In the event that a family member/caregiver or a cognisant resident-to-be accepts the offer of a LTC facility within 24 hours, one participant, MN, stated that: "*I tell them, 'Please contact your care coordinator, your care coordinator will contact the LHIN, and the LHIN will officially contact me.'*" Upon the official receipt of acceptance, MN explained that the follow-up task of the administrative staff is to arrange an early date for the signing of documents and the arrangement of moving into the facility. This example illustrates a potential type of communication that can occur between the administrative staff and the family members/caregivers or cognisant residents-to-be, and then with the LHIN. This multi-step procedure of passing information from one individual to the next shows the complicated back-and-forth nature of the communications that can take place during the admissions process.

After accepting an application, GH states the following as to what happens within the LTC facility in relation to the admissions process:

Once the applications are reviewed and an applicant is accepted, our clerical staff put together a notice for all of the departments that someone new, a new resident is entering, and a room number is assigned as per CCAC [Community Care Access Centre; currently known as LHIN]. *There's a welcome kind of package put together for the clerical staff, at the front we'll have a welcome George or Annabelle. Their room will have their name on it already, you know, just part of the welcome process. There's a welcome calendar of events put on their bed. That's all done by clerical. There's a resident chart put together by our clerical staff, and on the day of admission families are greeted at the front and if they're ready to do the admission then we'll take them immediately to do the admission. But usually we call on our social work staff to come down and meet and greet and take the resident and the family members and all the luggage upstairs to the room. Nursing greets them, housekeeping will come up and take the luggage, families have to write down all the clothing and all of that, they have to list it down, but then housekeeping will come and take all the clothing. Things need to be washed and they'll do that and bring it back the same day. The nursing staff start their 24-hour admission assessment. They do a head-to-toe assessment of the resident. Usually within the first three to seven days, all of the departments visit the new resident to ask them about food, likes, dislikes, do you want a change in your diet, recreation will pop by to talk about programing, spiritual and religious care shows up. The housekeeper or whoever is cleaning the room is one of the first greeters. Then the family member, usually the power of attorney, will come down and do the signing of the paper documents where we do admission agreements and authorization for services that they may wish to purchase and also get their signed consent for sharing of health information.*

GH's explanation of the step-by-step procedure at the LTC facility highlights many key staff members as they coordinate to welcome the new resident. However, much like the previous explanation regarding the division of labour within job positions, it is also important to note that, within certain homes, the administrative staff responsible for managing the admissions process may also be responsible for performing the tasks completed by the clerical staff or the social workers mentioned above (e.g., creation of the welcome calendar of events, the information package, and assisting residents to their rooms).

The communication among different individuals and teams demonstrates the significance of teamwork and cohesion of the administrative staff. The previous explanation of the division of labour with regards to the admissions process, and the lack of one particular job position for the performance of tasks, is another example of the involvement of different individuals during the admissions process. When discussing the administrative team and whether the admissions process is effective at their LTC facility, AB stated:

> *It is for now, just because my team and I, yes, we have this role to do. But for the managers that I work with, they have other duties as well and they manage their own department. So, if there is something that is of urgent nature then the file does get delayed a little bit, but my team is very good in maintaining that five-day response.*

In this passage, AB mentions the timeline in which the team has to effectively coordinate their tasks with one another to respond to applicants from the LHIN as quickly as possible. AB continues by stating that:

> *We do have our designated roles, mine is admission and then I have a colleague that does purchasing, and then I have another colleague that does resident accounts; but, because we moved into a new computer system, we're basically all backups of one*

another. So, when I'm away ill, or if I'm on vacation, then I have a backup to do all of my admission stuff.

The important factor mentioned within this passage is the concept of administrative staff being backups of one another. Following the previous description of the division of labour and the importance of teamwork, a few of the participants described taking on duties or sharing duties with other administrative staff to work as efficiently and productively as possible. IJ described this by stating: "*We have a good process here. Any kind of challenge that comes up, we have a great team*". This reinforces the collective efforts of the administrative staff on ensuring that every member of the team is working to complete their tasks. As a result, much like catering to the needs of the residents of LTC facilities and the desire to create a home-like environment, the administrative staff aim to create an open and caring environment in which they support one another. While this may have been representative of the perspectives of some of the participants of this study, it is important to recognize that this is not reflective of all LTC facilities and administrative staff, and viewpoints are subject to change depending on the internal beliefs and external conditions under which the administrative staff are situated in.

Administrative Staff in Pressurized LTC System

Despite the level of support and attempts of coordinated and effective admission of residents into a LTC facility, the expectations of the LHIN can create a stressful environment for many individuals. The long wait times for admittance into a LTC facility, the demand for constantly updated health information, the difficulty in refusing resident-to-be applications, and the short timeframe in which family members/caregivers (i.e., the power of attorney) have to accept a room when an offer is made, render the admissions process a frustrating experience for many administrative staff.

The long wait times before moving into a LTC facility are an integral but harmful component of the LTC admissions process. As noted earlier in this chapter by EF, there is: "*an extensive waiting list with more than 500 individuals at the moment.*" The waitlist is created by the LHIN based on the degree of need of the resident-to-be for 24-hour care service. As a result, an individual may be continuously pushed down the waitlist if more urgent cases happen to be presented to the LHIN. This is beyond the control of the administrative staff working at LTC facilities. In a very telling statement, IJ asserted that there was a need for: "*just more homes in general so that nobody ever has to die waiting to get in. Makes me emotional.*"

The participants all spoke to the ways in which the demand for beds/rooms drastically outweigh the resources that are currently present, and the challenges this reality presents for them in their work. It was evident that the administrative staff working with family members/caregivers of/and the resident-to-be are well situated within the system to experience the LTC system and identify areas that require improvement. KL stated:

> *More funding. More funding.* […] *Our hands are tied, and people are doing the best that they can with what is made available to us. As much as we live by resident first, it's very difficult, very, very difficult to do what we all love to do with what's available to us.*

When asked if they had recommendations to improve the LTC system, study participants spoke to increasing capacity in various ways. GH stated: "*I would want there to be hospitals for the elderly,*" whereas AB said: "*hire more nurses.*" EF stated: "*I think initially there's more respite care required. How that would come about, I don't know. I think the system probably has to look, or the ministry, at providing more beds.*"

These statements highlight the participants' perceptions of what is needed in the LTC setting. Interestingly, however, CD's comments stand out among the study participants with regards to how administrative staff may feel that their voices will not be heard despite having the privilege of observing where changes need to be made to improve the LTC system. CD described that before offering an empty room to an individual on the waiting list, LTC facilities have internal transfers that allow individuals who are interested in moving into a different type of room or individuals who may not have received their first choice of facility an opportunity to relocate. CD labelled this priority advantage as unfair to those who may have been on the waitlist for years, or to those who are just starting the process of applying through the LHIN. However, this feeling was followed by the statement: "*that's my personal opinion; but, I'm not the ministry, so they probably don't care.*" CD's comments suggest a degree of disempowerment that may be experienced with the administrative position as their direct observances and experiences will not be effectively heard or incorporated to improve the system by the LHIN or the ministry. All of these claims target the issue of the backlog and issues present in the current LTC admittance system, which ultimately contribute to the long wait times.

Due to the reported stresses within the LTC system, the administrative staff at LTC facilities experience a great amount of pressure to accept applicants once a bed/room has become available. This highlights the relative extreme-ness in the LTC system. On one hand, individuals and their families may wait for potentially years on the waitlist (and, in some cases, may even die while waiting). On the other hand, they have to make an immediate decision to accept an offer within 24 hours and then pack everything to move into the home within the next 24 to 48 hours. The starkness of these contrasts is troubling and yet reflective of the pressures on the LTC system as a whole, and on the administrative staff as well.

In the following excerpt, IJ outlines what typically happens when a room becomes available due to the demanding and pressurized nature of the waitlist:

> *If it's a good match for our home, then we communicate that with the LHIN. It doesn't mean that they'll come in,* [we do] *all of that when we get an admission, or deaths and discharges.* [In] *this position we deal with filling the rooms, making sure that all the different departments have the room ready. Communicating with the family to pick things up, which can be a delay in the process of filling the bed. As far as the admission goes, I communicate with the resident or the power of attorney, go over all of the details on admission day, what they need to have, preparing all of the documents, the admission agreement, all of the information that they're going to need.*

The organization of speaking to family members of deceased residents, removal of personal items of the deceased resident, and the preparation for the next resident to move in highlights the demand on the LTC system as the resident population is continuously being replaced by those on the waitlist. This portion of the LTC system paints the picture of a very institutionalized environment as the efficiency to maintain flow of residents is a priority task for the administrative staff. KL counteracts this institutionalized description by stating:

> *When you come in there is so much happening. You're being shuffled from one place to the next, it's a lot of stress especially if you're coming from home, a hospital is not nearly as much but for home it is. When you come into the home, now suddenly all this stuff is coming at you it's way too much information, it's so overwhelming for them. A lot of the residents, the family has seen the room, or the POA* [Power of Attorney] *but not necessarily the resident because the resident isn't well enough to come and go just to view the room. You're coming in, you haven't seen your new home yet, I can understand*

from that perspective why it's better to do that a lot of times. If they're coming with more than one person, we will take the resident to the room, everything will be prepared for the agreement, somebody will stay with the resident and the POA will go over the agreement. That way to me, that's ideal. It's a lot of stress. Too much is happening, and you'd really like to see where your new home is.

KL describes the process of moving in as experienced by the resident-to-be. As a highly stressing experience, KL mentions that the LTC facility is a home to which the new resident will have to become familiarized with. Furthermore, in addition to the stress of moving from one place of residency to the next, the vast number of tasks that need to be completed on the day of admission can be very difficult for the resident-to-be to tackle. This signifies that while the admission process may be stressful to the resident-to-be (and their family members/caregivers), some of the administrative staff and admission team members continue to make efforts on reducing that stress as much as possible within the extent of their abilities.

Because of the demands of the LTC system as a result of the long waitlist, EF shared:

It is very hard for us to reject unless it's blatant aggressiveness, really disruptive behaviours even though their medications been adjusted. Once we reject, we have to provide substantiation for that to the ministry, to the family [about why] *it is difficult for placement. So, if the LHIN feels that the justification, our rationale, is somewhat weak, they will fight back. Hospitals like to fight back and to push, "why, why, why?" Okay. I mean, their mandate is "clear that bed", it's just a reality, the whole system is under pressure.*

However, under extreme cases in which a refusal is plausible, IJ stated the following:

> *Let's say we're refusing them and there are specific reasons that we cannot take them, you know the environmental space, or we don't have the nursing expertise. So, those are two reasons that we can't take a new resident in this home. If a potential resident is refused, then the administrator would write the refusal letter and send it to the LHIN, send it to the person, and send it to the ministry actually, they get a copy as well.*

This illustrates that in addition to refusals being difficult to process, the justification and defence of one is also met with a multi-step procedure. Upon refusal of admittance into one LTC facility, the family members/caregivers will not automatically be withdrawn from the waiting list of their other LTC choices. However, in the event that their family member has been refused by every LTC facility, they will be removed from the LHIN system as well as the waiting list and will have to find alternative forms of care.

Chapter Summary

This chapter discussed the admissions process and how it impacts the lived experiences of the administrative staff. The role of the administrative staff within the multi-stepped, bureaucratic LTC system was presented, and the involvement of different parties affecting the work experiences of the participants was examined. The interactive efforts of the administrative staff within the admissions team was described, and the stressful and sometimes exhausting components of the LTC admissions system were highlighted. Ultimately, the frustrating nature of this pressuring system on the work of the administrative staff was mentioned alongside the voiced opinions of the participants on how to better the system.

CHAPTER 5

The Intangible Experiences

This chapter examines in greater depth the multiple unofficial and challenging roles played, and responsibilities undertaken by LTC administrative staff during the admissions process, as well as the emotional consequences (or lack thereof) of such responsibilities as the participants interact with family members/caregivers of and/or the resident-to-be. The boundaries between personnel duties and personal beliefs are examined in relation to their human connections as they reflect on their experiences with others and how they transfer to private sectors of their lives.

The Multiple Unofficial and Challenging Duties of the Administrative Staff

As noted in Chapter 4, the process of gaining admittance into a LTC facility was understood by study participants as a highly stressful, anxiety-inducing, and guilt-ridden experience for a large number of family members/caregivers. In addition to their tangible administrative duties and responsibilities (e.g., managing waitlists, verifying application details, etc.), the LTC administrative staff responsible for the admissions process have the difficult task of coping with and managing the emotional experiences of the family members/caregivers of and/or the resident-to-be. The challenge and complexity of the admissions process required the study participants to undertake multiple unofficial roles (i.e., not in their official job descriptions) in their interactions with residents-to-be and their families/caregivers. For example, KL stated: "*When you're doing the admissions, you get to be the sounding block for a lot of* [things]*: Quality control, pacifying the situation, and educating as well. But with some people it makes no difference.*" KL's brief statement succinctly points to the 'things'—listening, quality assurance, mediation, education—that they must juggle when working with residents-to-be and their

families/caregivers, none of which can be easily categorized as a tangible administrative or process-related functions. Furthermore, KL's final words, "*But with some people it makes no difference*," allude to the challenging emotions that arise for some during the admissions process such that they may reject or resist the advice, information, support, or comfort offered to them from the administrative staff. Similarly, IJ provided an example of the challenges associated when there is resistance to or rejection of the admissions process:

> *For the majority of* [family members/caregivers]*, they're emotionally charged. You know, you have the elderly who doesn't want to move in, and loved ones who are actually dealing. They're grieving because they're putting their loved one in a home and, you know, it's not easy. I've had a resident who came in, we were signing the agreement and the family was there, and she was like, "I can't stay, I'm not staying." So, she was lucid enough that she could say that. She didn't have a power of attorney. Her daughter, two daughters, knew that she had cognitive deficits* […] *I was quite involved with this one because I had shown the room to the lady twice, and then on the day of admission I was here. We did the signing up in the room and she just picked up her two suitcases and said, "I'm leaving." So, she left. She was able to leave because she was still deemed capable. So, her daughters were only powers of attorney if she was deemed incapable.*

While the vast majority of the experiences discussed by the administrative staff consisted of dealing with family members/caregivers, the above passage focused on an example of a cognitively capable resident-to-be during the admissions process. Even though the resident-to-be was personally involved in seeing the room that was being offered and signing the agreement, the transition from their place of residency into a LTC facility was still too difficult to cope with.

As such, they decided to reject the offer and pull themselves off of the waitlist after signing the agreement with IJ's LTC facility.

Many of the study participants spoke to their sense of duty to listen to residents-to-be and their families/caregivers throughout the admissions process, including after a resident has moved into the facility. CD stated that part of the job encompasses the need to: "*Let people cry it out and be a shoulder, sounding board, a non-judgemental, encouraging, and assuring* [voice that tells family members/caregivers] *that they're doing the right thing.*" For study participants, the role of being a listener also meant that, under certain circumstances, they were the ones to field questions and concerns from family members/caregivers that extended beyond the duties and responsibilities of administration. During such situations, the administrative staff took on the work of identifying who is responsible for that particular issue, for redirecting questions to the appropriate LTC staff member to retrieve a potential solution to a concern, or, and more importantly, for managing the emotional experiences of the family members/caregivers by illustrating that they (i.e., the LTC facility administrative staff) are present to help guide them through this difficult time. Vocalized by both MN and KL, this extra level of care went beyond the act of just listening to incorporating a need for triaging issues as problem-solvers or, in certain cases, as counsellors.

Expanding on the experience of being the 'first point-of-contact', KL stated:

> *I think being the first point-of-contact has a lot to do with it. People tend to think that you're the go-to*[-person]. *Not just me, but whoever is in this position, that you're the go-to for everything. How to get things done, how to pass on messages, when they need something. I often have people coming up to me and telling me about their health concerns or diet concerns.* […] *They don't know anyone when they come in here so it's*

the familiar face that you're always going to go to. It's fine, it just takes a little bit more time for them to get comfortable.

The work of ensuring the comfort of the resident and/or their family members/caregivers was not a formal job responsibility for the study participants, but all spoke to this additional work they undertook in their jobs within their LTC facilities, as well as the ways in which this additional intangible labour added to their already high volume of work.

As noted above, KL's statement of "*... with some people it makes no difference*" was in reference to the difficulty of wearing multiple professional hats amidst the emotionally charged context of the LTC admissions process where individuals may reject or resist the help of the LTC staff members. EF elaborated on why such behaviour arises by highlighting how the LTC admissions system is a challenging and demanding process to manage for the family members/caregivers. Based on their own experience of previously having loved ones in LTC facilities, EF stated:

> [I] *try to calm them down, and try to, what's the word, empathize, that's the word. Because they've been fighting the system. Finally, they got a bed offer and they're just, the dam has opened, it's a swell of emotion. I've got lots of people crying on the phone. So, a lot of it now is listening to them for a bit and saying, "Look, it's going to be okay. You're doing the right thing." I mean, guilt is huge! I say, "You're doing the right thing for your loved one, and not only that, you're doing the right thing for you", which is not going out on a limb, and I will explain that to them. I said, "Look, you're the caregiver, and they said, "Yes, yes, nobody understands. My siblings don't understand. I've been doing this forever. I've got my own issues," and when I hear that I say, "Right, and if this was to continue a little longer, your issues might become more complex and how are you*

> *going to be helping or benefiting your loved one? The pain is going to grow exponentially, so you're going to be in a tough bind." I say, "You're doing this for you and your loved one." But they have to take the lead, I mean this is someone I don't know and they're home in their environment. I've been through it myself with two parents so that helps. My grandmother was in long-term care for nine and a half years, and two parents who were resistive to going into long-term care until they got to a point where it was just misery. It was heartbreaking.*

There is a great deal to unpack in the above excerpt and particular attention to should be paid, first and foremost, to EF's characterization of individuals "*fighting the* [LTC] *system*" to get into the LTC system. When framed in this manner (i.e., a 'fight'), we can see some rationale for the stress, anxiety, and emotion among residents-to-be and their families/caregivers, including their rejection of or resistance to LTC staff members. It may be hard to transition into a LTC facility because those involved have had to endure a strained LTC system, a demanding admissions process, and essentially have 'fought' to claim admittance for the resident-to-be. As a result, and when combined with the emotional weight of the desire to take care of their loved one or a sense of a filial duty, the admissions process is when many of the concerns and emotional experiences of these individuals are vocalized and the LTC admissions staff are the ones who often receive these concerns first. KL articulated the ways in which the LTC system stimulates stress very well by stating: "*To live every day wondering when it* [the admissions process] *is going to happen, when you're going to get that call, and to psychologically be prepared to just have everything ready to go* [when it happens]" can be incredibly stressful for the family members/caregivers as well as the resident-to-be.

All study participants noted the discrepancy between the resources available at LTC facilities and the demands for LTC in the LHIN system as a concerning gap between the healthcare service that is currently being provided and what is actually required within the City of Toronto. As noted by the participants in this study, after going through a long waitlist and finally receiving an offer for a bed, the reality of a loved one moving into a LTC facility can finally sink in. This will lead to a release of pent-up emotions and feelings as family members/caregivers who were previously concerned with providing their loved one with the adequate level of care now have to deal with the other challenging, and often negative emotions (e.g., guilt), of transferring that burden to strangers. To this point, EF, as well as other administrative staff, will act as the listeners, empathizers, and grief counsellors or therapists to help show that moving a loved one into a LTC facility is "*the right thing.*" By telling the family member/caregiver that they are experiencing their own personal issues, and that delaying admittance of the resident-to-be into the LTC facility will only further complicate such problems and not be beneficial to any party, EF tries to reason that there needs to be a balance between self-care and care of loved ones for all parties to experience the highest quality of care. EF's past experience with having family members in LTC facilities and going through the admissions process as a family member was described as incredibly helpful in understanding and managing new family members/caregivers that are going through the process. However, not every administrative staff who participated in this study had this experience or referred back to their personal lives when discussing the multiple hats they wear in their job. As a result, this emotional management work can be a highly difficult duty to manage especially as it is not an explicit job duty to truly encapsulate the "*dam of emotions.*" While offering an empathetic ear

may seem like a simple thing, the responsibility is far more complex and emotionally impactful than anything that a job description could provide.

GH provided additional support for the notion of administrative staff as pseudo-counsellors by stating:

> [Family members/caregivers] *that might stick out are the ones where the families are having a hard time of letting go of their loved one. Usually, I have to bring out the box of tissue. It's a longer admission process just because we're talking about the loss that the family member is experiencing, and how to deal with it. There are also some families that have an Alzheimer parent who has behaviours,* [they] *seem very concerned as to whether or not the facility can handle the behaviours. And then again, you have to alleviate their concerns by letting them know that, "This is the business that we do. We have behavioural supports. We have staff that are very familiar with behaviours and are able to put strategies in place." Families come in and think that they're in a unique situation, but really, they're part of the population that has similar experiences.*

After fighting to obtain a room for a resident-to-be, there is a continued belief that a family member/caregiver should fight to ensure that their loved one has the best services provided to them. In many cases, this feeling was understood by study participants as a product of necessity because of the gaps in the system and guilt (to be presented later in this chapter). This was echoed by IJ who stated:

> *Families in general are positive. They're appreciative, they're relieved. But there are some who have unrealistic expectations. So, let's say an example would be if their loved one comes in a wheelchair, very weak, can't walk. We have a physio team* [physiotherapist and assistant] *that would work with them.* [Their] *expectation is that* [the

> resident] *gets treatment, exercises three times a week. Sometimes, families want them to be walking tomorrow and that's not going to happen. Again, that goes back to guilt. Their loved ones are here so they have to be super advocates and try to get more and more for* [them].

It is important to note that the study participants didn't locate guilt as the motivation for all negative or stressful exchanges with family members/caregivers. Participants spoke to a range of perceived motivators for family members'/caregivers' stress. One being the desire of family members/caregivers to ensure that the resident-to-be receives the same level of attention and personalized care as they would at home. GH summarized this point by stating:

> *You realize that, oh my gosh* […] *this family member is going to require a lot of attention. And usually they're acting like that because they're stressed over the amount of care that they've been providing, and it's a loss for them too because they're losing someone that they've been providing for and spending a lot of time with.*

EF echoed a similar level of awareness: "*These* [family members/caregivers] *are giving care in the community, and it is for their loved one or family member.* [Now] *they're coming here for care and they're looking to pass on the torch.*"

In addition to coping with and helping to alleviate some of the emotional turmoil experienced by the family members/caregivers, some of the study participants spoke to their sense of responsibility to act as protectors of the current residents and, in some cases, as advocates for or protectors of more particular residents-to-be. AB provided an example of one instance during which they took on the role of advocate:

> *There's one* [case] *where I kind of had to advocate for the client because she was a transgender female and she was on my list for two years. She was eventually admitted to another long-term care home before transferring to* [name of LTC facility], *and she was in a four-person room. The administrator here at that time wanted to put her in a private room with a private washroom. And I didn't think she really wanted to admit her, but eventually the private room with the private washroom came up and I said, "You know, can we admit her?" 'Cause at that time we had two* [transgendered individuals], *and one passed away recently, and they wanted to put both of them together. But, it wasn't a good idea because one is kind of cognitively impaired and the other one wasn't. So, it wasn't really going to work out. We were going to put them in the same semi-room with their own private washroom. But I didn't really like the stipulation that we put on these transgender females. I can understand her, the former administrator's side, that it was for their privacy and for their safety. Also, if they were to share even a semi room, the other roommate might not understand, the family might not understand. So, eventually, I had to fight for them to actually come in 'cause they were on my waitlist for so long.*

This passage highlights the conflicting nature of wanting to protect both new residents-to-be and current residents of a LTC facility. The desire of the administrator to provide a transgender resident-to-be with a private room lengthened the process of admission leading the administrative staff to seek a resolution. AB further explained by describing:

> *She was in a four-bedded room with ladies. But, the concern with the administrator was that if we were to put her with a resident that didn't understand, or if that resident could understand and they saw something they weren't supposed to see, or if family members*

saw something they weren't supposed to see, then there would be issues. So, it was more for the transgender lady's safety and privacy.

The above passage highlights that while this case, in particular, may seem to have been more complicated in nature because of the circumstances of the resident-to-be in the LTC facility context, the safety and privacy of the resident-to-be were of utmost importance. Furthermore, while AB actively took on the role of an advocate for or protector of the resident-to-be, this is not a formal job duty that would be overtly expressed in any job application summary or terms of reference. Yet, this work was significant in helping not only the resident-to-be in gaining the health and personal care service that they required, but also in helping relieve some of the tension that is found on the LTC admission system and the long waitlists.

Juggling these duties can be potentially stressful and exhausting for the administrative staff especially considering the nature of such responsibilities (i.e., consistently managing the emotions of others). For example, to manage future emotional concerns expressed by the family members/caregivers, CD stated: "*I will be honest and tell* [the family members/caregivers] *that their loved one will complain and won't like moving in for a month. But everyone has their adjustment period to settle in and then moves on.*" While this approach may potentially invite greater levels of questions and concerns, as well as stress, from the family members/caregivers, CD suggested that it works to alleviate and potentially reduce future stressful encounters. While every study participant viewed these intangible complexities as a part of their job and devoted themselves to assisting the family members/caregivers, we cannot overlook that this emotional management workload is a lot to handle for many individuals depending on the LTC facility, the division of labour employed within the facility, and the level of collaborative team effort present.

The Consequences of Managing Emotions

As previously discussed, one of the main unofficial duties of the administrative staff involves the management of emotions of others while working with people experiencing stress and anxiety. From family members/caregivers to the administrative staff, the admissions process is a stressful process for all involved, including the LTC administrative staff. To illustrate, IJ spoke to the negative emotions that arise in the admissions process:

> *You feel terrible, right? You feel terrible, and you feel stressful because we're told by the ministry that* [the convalescent residents] *can only be here for 90 days and we can't keep them for longer. So, we have to do what we can and talk to the families and sometimes they don't have families. I mean we want to, ensuring resident safety, client safety is the most important so we wouldn't put them out on the street, ever, that would never happen, but certainly we have to discharge them from our program after the 90 days and hopefully they'd always be safe somewhere whether it'd be the hospital or* [with] *their family members.*

The passage above illustrates the emotional involvement of IJ in relation to their sense of duty and the residents of the LTC facility. The lingering concern associated with a convalescent-care resident that has to leave a program, and the complexities of dealing with those that are adamant on staying at the LTC facility, have a significant toll on the administrative staff.

Additionally, whereas in the above example some cases were mentioned to be difficult because of the inability to reach the family members of a resident, other cases are difficult because of the inquiries of the family members/caregivers. For example, EF stated:

> *Sometimes in the admission process, we will encounter applicants who for some reason will perhaps be rejected, and because of the demand, and what's the word, what the*

family is looking for, expectation, that's the word I'm looking for, there will be push back. They will go to the ministry, they will go to the LIHN and it's difficult because were not doing it personally but, in a case like that, it can be a little unnerving. If somebody has called and stated, "Look you guys are out of touch, here's the situation, you told me this, and now it's this," we try to substantiate our perspective and point of view, what our obligations are to that individual, and that we have to protect our vulnerable population. They might not be in agreement to that. Something like that. It will rattle you up emotionally because you feel, I personally feel like, yes, I know it's somebody fighting to place their loved one and they feel that we're not doing our job properly, or misrepresenting, or something like that, and basically we're in the wrong. So, we now have to substantiate ourselves and where we're coming from. It's difficult when you have a confrontation with someone whether we're justified or not. We have to be fair to everyone, we have to treat everyone equally, so when somebody gives us a push back with that regard, yes, I take it personally. It will affect me personally; I mean I'm only human.

It is important to highlight that all participants described their encounters with family members/caregivers as positive experiences despite how demanding some family members/caregivers may have been. IJ claimed in their interview that, "*90% of our families are very supportive and very appreciative, and they're wonderful because they volunteer.*" EF's statement was specific to an instance when a family member/caregiver that has gone through the LTC admission system and waitlist and, upon consideration for a room at a LTC facility, was rejected. As previously discussed in Chapter 4, rejections have to be greatly substantiated as LHIN's primary goal is to get residents-to-be off of the waitlist and into homes. However, in an

instance when a rejection has been approved on the grounds of the resident-to-be not being a fit applicant for a LTC facility, then the family members/caregivers may decide to fight back out of frustration and, in so doing, take their frustrations out on the administrative staff who serve as first point-of-contact for the resident-to-be and their family members.

It is also noteworthy that one participant, GH, provided a different perspective regarding the effects of managing other peoples' emotions and stresses during the admissions process:

> *It doesn't* [affect me] *because I'm a veteran doing the admission process. I've done it for a long, long time. Usually when we're dealing with the stress and the families, it's the families that want to talk, so it's about having the ability to lengthen the admission process with the power of attorney so that we can hear them out and answer all their questions and help them with next steps as* [they] *need time for* [themselves]. *They're going through grief, there's a huge sense of guilt by families for leaving their loved ones here, and for some, if it's a husband leaving his wife here, we tell them to take time for themselves, to get some sleep because some families are sleep deprived. But we welcome them back into the home so that they can share the daily experiences that their loved ones are going through.* […] *For me, it was stressful initially 'cause I had to get to know personality types of family members. I had dealt with a lot of families in my previous job working in long-term care, but now you're dealing with money and consent and sometimes there's families that can't believe how much they have to pay for a long-term care stay, and you're dealing with different families. So, it's just a matter of recognizing the type of family walking through the door.*

In this passage, GH explains that their vast experience in the role provided them with the perspective and the ability to better distinguish between their work and sense of stress (or lack

of). While managing the emotions of family members/caregivers was initially a more stressful experience, this process became manageable over time through the development of personal skills and self-awareness, including the ability to recognize different familial situations and to prepare for the negative consequences that arise from tense familial interactions.

It is important to note that GH did speak about the stressful nature of work but that, when doing so, it was specifically in relation to families who are struggling emotionally with the prospect of their loved one entering, and the costs associated with entering, the LTC system. GH also explained that the relationship dynamics between and among family members contribute to the stressful nature of their work as well. More specifically, GH said:

> *The stressors come into play when you have families that are divided where one child says, "It's time for mom to come to a long-term care facility" and the other two say, "No" and then there's struggle between the family members. That is a bit stressful only because we have to identify that out to the team that there's a lot of discourse and miscommunication between the family members and what their wants are for the* [resident]. *That can be very difficult.*

GH further added:

> *We will sometimes get family members that are angry. But again, it's a personality that they have, they're angry about everything; It's not just this admission process. And you realize that they will become a difficult family to deal with based on their demands, but that only affects work per se. Those personalities are felt by the entire care team. I may see it and identify it upon admission, but then I pass on that information and then others have to deal with it.*

According to GH, gauging the character of the family member/caregiver and effectively communicating this observation to the other care teams at the LTC facility are perceived to be components of successfully completing the job.

Interestingly, IJ also noted that families, rather than the residents, and their emotions add challenge to the work of the LTC facility staff:

> *A lot of the times the challenge is with the families 'cause they're the ones who are grieving. The residents are fine, they're here, they're just trying to fit in and get adjusted to their home. We have social workers who work with the residents and families to kind of reduce the relocation trauma of being in a new place. Families are usually the ones who have the most difficulty and because they're grieving, because they're feeling guilty, we're the ones that they take it out on.*

Arguably, the two most noteworthy elements of IJ's comments are: a) the description of the families' reactions to the admissions process in terms of grief, and b) the assertion that the LTC administrative staff are the ones who bear the brunt of the families' grief- and stress-related responses ("*We're the ones that they take it out on*"). IJ later stated in the interview: "*There's lots of lingering effects in this job*" when it comes to working with the family members/caregivers who are experiencing many emotions, and: "*They're going through the grieving process. They're going through their own guilt.* […] *If you're human, it has to affect you, to be thinking about, 'How is that daughter when she went home? How is she feeling right now?'"* While administrative staff are not formally responsible for managing the emotions of the family members/caregivers during the admissions process, they do so, and the impact of their interactions with the families/caregivers intrude on their personal lives as illustrated above.

Participants did note that, at times, the resident-to-be is the person who stimulates the stress (e.g., noted in IJ's anecdote raised earlier). However, some study participants located this behaviour in terms of ill health. For example, EF commented: "*Sometimes their nature might be because of their illness and that has to be understood.*" This comment could be interpreted as an attempt to reinforce the need for understanding, and patience that the administrative staff are required to have while working with the resident-to-be during the admissions process. However, by employing an amorphous concept like *"nature"* and implying that certain behaviours from residents-to-be need to be accepted, the potential difficulties experienced by the administrative staff during their interactions with the resident-to-be are deemed as normal and expected components of the job. While this understanding removes potentially negative outlooks from the physically- and/or cognitively-impaired resident-to-be, it depreciates the challenges that are experienced by the administrative staff.

AB provided an alternative perception regarding the normalization of personal care dependency as a component of older adults through the statement:

> *Our convalescent program is basically a rehab, like a very short-term rehab program for any resident that need that care before going back home because they have a fracture or what not. So, I've noticed that a lot of younger people are applying to that program and then, there are long-term care residents that are younger* [as well]. *I'm not sure if you're aware, but in the home that I came from* […] *we do have a young person's unit so people there are from between the ages of 18 to about 45, so they're very young. So anytime I get a client that comes for a convalescent that's young, that scares me* […] *That can happen to any of us.*

This passage illustrates a LTC facility that has a 'young person's unit' devoted to a specific age-group of residents. This incident highlights the eligibility criteria set out for gaining admissions into a public LTC facility within the City of Toronto. It also shows that despite LTC facilities being devoted to providing 24-hour medical and non-medical needs to its residents, the concept of a younger resident is still more concerning than that of an older resident. In fact, while experiences of younger residents-to-be were not excluded, almost every participant spoke exclusively about the family members/caregiver of older residents-to-be. With very little attention being devoted to younger residents, this mindset normalizes that healthcare and personal care dependency is a component of older age. As such, it is viewed as abnormal to have younger residents-to-be located within the same institution as older residents.

~~Personnel~~ Personal and Human Connections

All participants in this study spoke to the interactions with others, whether residents-to-be or the residents' family members/caregivers, in ways that emphasized human connections with sensitivity to personal vulnerability. Oftentimes, this was expressed through such language as "*human nature,*" "*being human,*" "*this is life*," or even references to the LTC facilities as "*family*" or "*home*" rather than a facility, institution, or business. KL stated that a responsibility of an administrative staff is to: "*give* [the family members/caregivers] *confidence so that they know that* [after the admissions process,] *this isn't it. We're not just shaking hands and moving on from this business agreement.*" IJ stated: "*I think everybody would want their loved one to remain independent and cognitively alert, and I guess not have to depend on strangers 'cause that's what we are until we become their family*" and, later in the interview: "*This is their home, so we want them to be happy here.*"

In describing interactions with family members/caregivers during the admissions process, EF described:

> *Just from human nature, when you see someone that's quite friendly, or aggregable, or in a good mood, or the family are really appreciative, that sticks out* [as a memorable encounter]. *It's just part of human nature and being human. When somebody is very challenging or abrasive, that'll stick out as well. I mean it's the extremes of the spectrum. But it is part of our not just job, but it's our duty for the resident coming in to help put them at ease, to resolve any questions or issues they might have. Sometimes they might not know how the system works or what is required, so it might be a bit of handholding and a bit of patience to go through the whole thing. But in the end, once* [the family members/caregivers] *understand what we're going to provide, and what we're going to do for the family, it usually ends up well. I mean there are people who just have a more difficult time and are more challenging and that's just anywhere in life and in any location.*

For EF, the concept of "*human nature*" informed a sense of duty to the people going through a stressful point in life. The common use of the term "*human nature*" by study participants was often put forward as a way with which to make negative encounters with others understandable and yet, in so doing, reproducing the idea that guilt and grief are normal parts of the LTC admissions process.

A number of participants in this study spoke to their own personal experiences with their own family members in LTC facilities. It was KL's past such experiences that sparked the interest in working at a LTC facility:

> *My great-grandfather, when I was in my early 20s went into, and it was a city home too, went into long-term care. Two, three days a week I would go to visit. It was so traumatic for me, so incredibly traumatic. I would be leaving in tears. I knew him, he was in the military, he was hard working, he was successful, very strong family values, and to see him in this condition, and not just him, but to walk through the halls and see what comes at the end of it all, it resonated, and it was so depressing and terrifying for me. It got to the point where I couldn't go as often. I would go once a week and it would take me about a week to somewhat recover. And then, I ended up becoming a PSW years later. So how that happened, I don't know. But part of* [it] *was that this is the reality, this is life, we are human. There's a beginning and an end, and I want to make those last few years or some of the most difficult times in our lives as positive as I can. So, for* [the] *eight hours a day that I'm* [here] *I want* [the residents] *to be happy, as happy as they can be. To forget some of their ailments, their living arrangements, and to enjoy life.*

The past personal experience of having a loved one admitted into a LTC facility informed (and informs) KL's current perspectives on LTC and their approach to and sense of duty in supporting others going through what KL had previously experienced.

MN similarly drew from their own experiences of starting work at their LTC facility as impactful of changing their worldviews and approach to work:

> *In our culture, putting your parents into a nursing home is not a good thing, generally, back home. But when I started working at this facility, and I saw how it works, then I* [would] *consider* [moving into a LTC] *in the future if it is needed. But if it is not needed then I won't. It depends, because I don't want to be a burden to my daughter or to my family. But it* [has] *open*[ed] *my perspective, how do you call it, it open*[ed] *my mind when*

> *I started working in this facility. Because you also have to consider the stress that it brings to your family when they have their own life that they have to take care* [of], *I get that. I don't want my only daughter who should be having her own life being single and taking care of me.*

This passage highlights that gaining exposure to working at a LTC facility, more specifically the LTC facility at which MN is currently located at, allowed MN to transform their previous cultural views and norms into becoming accepting of potentially moving into a LTC facility. By understanding the process of care at a LTC facility, MN's desire to not be a potential burden to their loved one(s) fostered the idea of potentially becoming a resident in the future. As expressed by every participant during the recall of their experiences with family members/caregivers, having a loved one move into a LTC facility is the last option for many individuals. CD described this by using the statement, "[You're] *not horrible*" to the family members/caregivers grappling with feelings of guilt and grief. Thus, exposure to the care at LTC facilities and acceptance of it as a potential home in the future can also be a key factor in making the admissions process less stressful for the family members/caregivers, residents-to-be, and, in turn, the administrative staff as well.

In an effort to alleviate stress, all participants mentioned the importance of providing the best care possible. Comparing residents coming from the community to those coming from the hospital, KL stated:

> *People coming from the community, for me, those are the most challenging from my experience. I say that because these people have been mothers, fathers, had careers, independent, had worked probably their whole lives and now are in a community-living setting. I mean, it's not ideal for anyone but it is a really difficult time in someone's life,*

> *exceptionally difficult in so many aspects. Their belongings, most people have a home full of belongings, that's their home and now* [they're] *downsizing to literally a room, and a small room. Again, community living, you're in a home full of strangers, everything is so foreign to you so that alone, is difficult enough. Coming to terms with the fact that you need this assistance, that you're no longer independent, you're not paying your own bills, you're not selecting your own food. I mean even though there are options, they're not really your options. You are reliant now. You are reliant on people.* […] *To me, I think it's demoralizing to the majority of the residents coming from the community.* […] *When they're coming from the hospital, they're like, 'This is my room?' They're so happy and grateful. That's good.*

This passage highlights how, despite the desire of the administrative staff to provide the best quality of care, the LTC system itself is not flexible or responsive enough to be a desirable and primary option for many family members/caregivers or residents-to-be. However, while perceptions of LTC facilities can be drastically different depending on the pre-move residency, the outlook of the administrative staff remains the same as they treat the provision of service as 'client focused'. To illustrate, EF stated:

> *Anything with healthcare, it is client focused and it should be. It is also the vulnerable sector, like with children or the elderly, we shouldn't just make it an institution and provide housing. These are people who have benefit, not benefit, they have actually provided benefits to society through employment and contributions throughout their lifetime. We owe them that respect and care at this stage of life, where they might be facing issues, and their families, as a result, may be having issues. We owe it to them.*

This quote represents three significant ideas: a) the prioritization of the client-focused and service-providing nature of the healthcare and LTC systems; b) the justification of the fact that the residents of LTC facilities deserve a high standard of care because of what they had provided to the community and society during their independent, cognisant, and autonomous years of life; and c) the need for the justification of the care provided hints at the fact that society typically looks down at the older population and views them as valueless or of lesser value because of their dependence on others.

Chapter Summary

This chapter discussed the multiple unofficial and challenging duties of the administrative staff as they tackle their work with the family members/caregivers and residents-to-be during the process of admissions. The impact (or lack thereof) of the emotional consequences of managing the emotions of others was highlighted. The interplay between the personal beliefs of the administrative staff and their implicit personnel duties were also examined as participants spoke of the effects of their experiences with family members/caregivers and residents-to-be on their own worldviews. The following chapter will present the Discussion and Conclusion as findings from this research project are analyzed and discussed in comparison to the extant literature that has already been published.

CHAPTER 6

Discussion and Conclusion

The purpose of this research project was to explore the perspectives of the administrative staff working face-to-face with typically older persons and their family members/caregivers, with particular attention given to the LTC admissions process. As stakeholders with significant insight to the phenomenon of admittance into LTC, this research project employed a phenomenological approach to address the central question of: *What are the lived experiences of LTC administrative staff working with families/caregivers during the admissions process?* Drawing together the accounts shared by seven administrative staff who participated in this study, this concluding chapter will provide a summary of the dominant research themes, evaluate the current findings relative to the small body of extant research on this topic area, and identify current limitations as well as future areas of inquiry. This chapter will also present the recommendations from the administrative staff on improving the LTC admissions process, system, and management of the duties within the job position of the 'administrative staff.' This information will complement and extend the discussion of potential areas of future research through the lens of the administrative staff as individuals who have extensive experience with the admissions process.

Pulling the Thematic Threads Together

Given the paucity of information on the experiences of administrative staff, findings from this study highlight that administrative staff are an integral part of the LTC admissions process. This is not only because of their expertise in managing the complex and multi-stakeholder bureaucratic and administrative process involved in the LTC system, but also because as the first point-of-contact in the LTC admissions process, they take on so much more in their interactions

with the incoming residents and the families/caregivers (e.g., problem solver, counsellor, welcome party, etc.). Many of these actions, activities, and contributions are not found in their official job descriptions, and yet administrative staff are, or feel expected to perform them as their professional and personal responsibilities. Thematically, this study foregrounded that the highly pressurized nature of the LTC admissions system, bookended by extremely long wait times and then a hyper-accelerated acceptance of admissions and move-in period, is stressful for all involved stakeholders (the residents, families/caregivers, and administrative staff).

Similar to past research findings, roles involving leadership, gauging situations/emotions of residents and families/caregivers, being coordinators of information, and being team workers were highlighted as crucial components of successfully managing the admissions system (Finley et al., 2007; German et al., 2004; Kash et al., 2014; Vogelsmeier & Scott-Cawiezell, 2011). As the findings reinforce the multi-stepped and demanding nature of the LTC admissions system, administrative staff were illustrated as a population that is responsible for managing official job responsibilities, as well as dealing with the consequences of the implicit job expectations. Much of the focus on addressing the issues arising from the latter are targeted at the individual level by the administrative staff themselves as opposed to gaining systemic recognition. The emphasis on effective teamwork (which was also reported as a finding of this study as participants spoke on addressing issues/concerns collectively as a team, or dividing labour when possible) falsely ingrains the idea that complications regarding the LTC admissions process can be sufficiently resolved at the level of the LTC facility.

Long wait times, lack of beds and infrastructure to support the demand on the LTC system, limited funding, and waitlist policies ensuring priority placement/relocation to current residents are all critiques of the LTC system that were highlighted in both this study as well as

past research (Born et al., 2011; Goffin, 2016; OLTCA, 2017). None of such issues can be addressed at the level of the LTC facility or by the administrative staff. Thus, the LTC admissions system remains stagnant and unchanging as administrative staff have to bear with the circumstances and deal with receiving the brunt of the negative emotions of family members/caregivers as a result of such problems (in addition to handling the expense of care). This study presents critiques and flaws of the LTC admissions system, and more broadly, the Ministry of Health and Long-Term Care, in action as it highlights the extreme and implicit occupational demands on the administrative staff.

As noted in Chapter 4, one participant described the experiences of the families/caregivers as individuals "fighting the system" to get their loved ones admitted into a LTC facility. This was a noteworthy observation because it captured the perceived and, in some cases, real battle that family members/caregivers struggle through in order to obtain admittance for the resident-to-be. While there is a vast amount of literature examining the experiences of the family members/caregivers because of the gaps in the LTC system (e.g. include, Buhr et al., 2006; Cheek & Ballantyne, 2001; Davies & Nolan, 2004; Dellasega et al., 1995; Kellett, 2001; Nolan & Dellasega, 2001; Pearson et al., 2004; Ryan & Scullion, 2000), the direct impact of such emotions on the administrative staff had been left unexamined.

This study provided novel findings to address such gaps in literature. In order to fully capture the lived experiences of the LTC administrative staff, Chapter 4 provided themes that reinforced and highlighted ideas previously discussed in association to the work of administrative staff. Chapter 5 provides new information and builds on the experiences of administrative staff during the admissions process by paying closer attention to the intangible elements of their experiences working with residents-to-be and their families/caregivers. As

noted already, their official work duties – including the requirement of coordinating with a range of other professionals in the LTC system – paired with their implicit and challenging responsibilities showed the extent of the involvement of the administrative staff as they managed not only the paperwork associated with admissions into a LTC facility, but also the personal and emotional interactions with family members/caregivers and the resident-to-be. Drawing from the participants' own words, from being hand-holders (not to infantilize families/caregivers, but to empathize), listeners, counsellors, arranging welcome packages, introducing families/caregivers to LTC staff, and addressing problems that arise after moving in, administrative staff assumed responsibility for an extensive range of work and activities that resides outside of their job descriptions. Management of these implicit responsibilities has not been previously discussed to examine its effects on the experiences of the administrative staff. However, one finding from this study highlights the extensive usage of gauging situations and emotions, and in turn communicating these assessments to other staff members. This issue has been previously assessed as administrative staff are said to be responsible for bridging the gaps in quality of care expectations and miscommunications between family members/caregivers and other LTC staff (Duffy et al., 2001; Pillemer et al., 1998). While this has been voiced to be a beneficial skill attribute by many individuals within this field, it is also important to highlight that passing of such judgements of may not always serve to benefit the provision of care by the LTC staff. This could be a result of LTC staff falling into a state of self-fulfilling prophecy under the belief that family members/caregivers are more demanding simply because of their exaggerated and emotional state of being when, rather, it could be due to the frustrations and challenges that arise from navigating through or tackling the LTC admissions system.

Regardless, findings from this study (with the exception of one participant) indicated that certain events and experiences with residents-to-be and families/caregivers have the power to leave lingering feelings/emotions that negatively impact the state of well-being of the administrative staff. This was a key insight of this study as participants highlighted how the LTC system left it to the administrative staff to figure out their own ways to cope with the unpleasant elements of their work. In fact, because all the extra intangible work they do is not in their job descriptions, it is frankly unclear how much attention is being paid by LTC facility management, or even higher levels of governance like the Ministry of Health and Long-Term Care, as to the support the administrative staff may or may not need. This is troubling since it individualizes the challenges associated with managing the LTC admissions process – managing the stress of it falls on the shoulders on the individual rather than being approached collectively or systemically. Similarly, by taking a client-satisfaction approach to LTC, care for older adults is not being approached collectively, but rather individually. This prevents broader areas of concern from being effectively addressed, as caregiving is only geared towards those who managed to secure a residency at a LTC facility. As such, both formal and informal caregivers become focused on meeting the needs of one individual instead of working to improve the system. Due to this, it is crucial to examine and understand the experiences of different stakeholders in order to identify and potentially pose solutions to bettering the admissions process (Kirchner et al., 2012).

I argue that the Ministry of Health and Long-Term Care needs to recognize that being more-than administrative staff (i.e., listeners, welcomers, etc.) to the family members/caregivers can dramatically affect the emotional and mental state of the administrative staff. Yet, these additional responsibilities are not treated with the appropriate level of attention – whether it is in

the form of providing training or providing methods of effectively coping with the unpleasant elements of the admissions process. There is no clear indication that these issues are being addressed by the MOHLTC or the LHIN, which leads to the troubling deduction that the administrative staff are responsible for seeking support and managing their emotions on their own. The down-loading of work to the level of individuals and the subsequent individualization of coping techniques devalues the work that the administrative staff perform as supporters of family members/caregivers during the admissions process, and places the burden of care on the individual instead of taking a systematic approach. Furthermore, while there is no clear indication that these issues are being formally addressed by the MOHLTC or the LHIN, there is also some indication that administrative staff themselves have consented, to certain degrees, their need to manage the challenges of resident admission into a LTC facility specifically, and the LTC system more broadly, on their own. Some of the recommendations related to improving the LTC worksite that study participants raised, in addition to their other comments and anecdotes about their lived experiences, underscore this point.

Recommendations of the Administrative Staff

The central aim of this research project was to examine the lived experiences of the administrative staff working face-to-face with the family members/caregivers of the typically older resident-to-be during the admissions process. However, during the course of the interviews, the participants provided a number of recommendations on how to improve the admissions process/LTC system, and better manage the duties associated with the job position of the 'administrative staff' for future administrative workers. While this information is not directly related to the central question of this project, it does underscore the challenges of the LTC system and, indirectly, the consequences of the stressful system on the stakeholders involved in

the admissions process. The recommendations from the participants reflect not only their views about the job, their duties and responsibilities, but also their ideas on what is needed to improve the LTC system for all.

Based on the experiences of the administrative staff working with family members/caregivers of the resident-to-be during the admissions process, and with particular attention to their duties in association to the admissions process, the following collection of recommendations for future applicants interested in working within this general position has been collected. GH stated:

> *Some of the things I would say is, learn in-house policies and procedures thoroughly, understand what different positions in the home do according to their departmental manuals, take as much education as you can from the ministry of health in regards to the accommodation process and fees that are being charged, and don't be afraid to be a continued resource for family members of resident, and staff.*

Similar to GH's statement, KL highlights the idea of becoming a continued point-of-contact for the family members/caregivers upon completion of the admissions process. However, KL goes on to mention that helpfulness and the desire to help and seek for information on behalf of others should be a developed character attribute as individuals tend to reach out regarding information that is outside of the scope of duties and responsibilities of the job position. KL also stated:

> *For somebody doing this job, prioritize and time management. Again, there are so many variables in the position that you never know, you never know. There's no such thing as planning out your day. It doesn't happen. So, staying on top of everything so you're*

prepared, and you can allow for these interruptions to happen, that'll be key, that'll be key to being successful.

As an extension of developing or possessing character attributes beneficial for this job position, IJ discussed the significance of effective communication skills:

I think open communication, that's the best way to make each team member feel a part of the process. There's a group of us from the beginning to the end. I think [we're] *always keeping in mind that we're all about the residents first. How are we going to make this a great transition for the resident, for this admission process that we have?* [...] *Always looking for suggestions, I think that's important too.*

KL continued the trend of the significance of communication by also incorporating the importance of knowledge:

I'm pretty upfront with people that if I don't have an answer for you, I will get an answer […] *I think being honest with people about these things,* […] *people respond to that very well and are generally very understanding.*

While some aspects of the above recommendations were discussed more extensively as significant research themes, the inclusion of these passages were significant for expressing the perspectives of some of the administrative staff on the duties and responsibilities of the job. At face-value, these recommendations highlighted certain perceived skills and attributes that were believed to be beneficial for future applicants of the position of 'administrative staff.' However, these recommendations broadly define and normalize the implicit and challenging duties, and the multiple roles of the administrative staff during the admissions process. They also reinforce the individualized nature of managing duties and accepting stress-inducing responsibilities that are

not being acknowledged by the LTC system. Having time management skills, communication skills, and actively learning the policies of the LTC system may be posed as necessary tools for completion of tasks, but, they do not attend to the larger or more structural problems with the LTC admission system.

Strengths and Limitations

As far as I am aware, this research project is a first of its kind given its examination of the lived experiences of the administrative staff working face-to-face with family members/caregivers of typically older residents-to-be at LTC facilities within the City of Toronto, and through a phenomenological lens. A strength of this study was in exploring and understanding the lived experiences of the small sample of administrative staff involved in the process of LTC admittance. As significant stakeholders on the phenomenon of LTC admittance, their experiences and perspectives have been largely excluded from the body of literature studying the admissions process. As a result, this study provides the necessary thematic analysis of the experiences of its seven participants and advances understanding of the admissions process. Future research on the lived and social experiences of the administrative staff will continue to further address the gap in literature by including and acknowledging this population as significant members of the admissions process.

The findings of this study could have greatly benefitted from the inclusion of demographic information (e.g., level of education, relevant training prior to beginning work, etc.) in order to better contextualize the experiences of the administrative staff. Additional benefits could also be gained from examining the perspectives of other stakeholders involved during the process of admissions. The perspectives of such members on the work of the participants would have provided a more inclusive understanding of the experiences of those involved in the LTC

admissions system. Additionally, the participants of this research project come from a very small population (‘administrative staff’ from the City of Toronto LTC facilities). As a result, expansion to include more individuals could enable examination of the effects of factors such age, gender, race/ethnicity, and socioeconomic status without threatening privacy and confidentiality agreements (all of which were intentionally excluded to maintain anonymity for this research project). Another limitation of this research project was the fact that the job descriptions of the ‘administrative staff’ were not analyzed on paper to truly understand what each job title encompassed, or how such duties/responsibilities were initially communicated to the participants.

As previously discussed, with regards to methodological limitations, it is not believed that the use of selective transcription hindered the data analysis procedure as recordings were listened to multiple times and transcriptions accounted for the vast majority of the spoken words of the participants.

Future Research Directions

The intent of this research study was to explore the lived experiences of the administrative staff working with family members/caregivers during the admissions process. The findings from this study were novel as they examined the perspective of an understudied population. The vast majority of the literature studying the admissions process focuses on the experiences of the resident-to-be or the family members/caregivers while ignoring the third party involved in ensuring that this process can be completed. It is hoped that the analysis of the experiences of the administrative staff from this study highlight the need for further examination of this population. Furthermore, future research should address the existing limitations of this research project and expand to analyze this population within different metropolitan and

geographic locations to better understand the lived experiences of the administrative staff and perform comparative analysis of emergent themes. Additional potential research directions include studying the perspectives of other LTC staff on the work of the 'administrative staff' and their involvement as key members of the admissions team. Or perhaps, studying the long-term effects of stress induced from work associated with LTC admissions.

It is absolutely imperative to understand the perspectives of different stakeholders in order to eventually seek systematic improvements that in turn better the professional and personal lives of the administrative staff. Any improvement to the LTC admissions system will have a positive effect on the lived experiences of the administrative staff.

Lastly, it is important to recognize that the experiences of the administrative staff expand beyond understanding the professional nature of their work (the explicit duties and responsibilities that are outlined in their job description). It is also important to recognize that workplace stress can be a consequence of interactions that are not directly linked to the explicitly listed duties and responsibilities. In doing so, the value of the work performed by the administrative staff can be acknowledged appropriately and efforts can be made to appreciate them within a potentially better LTC system.

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Appendix A

Key Terms

Administrators/Administrative Staff: For the purpose of this research project, administrative staff will be known as the individuals responsible for the face-to-face assistance of the resident-to-be and their family/caregivers during the admission process into a selected LTC facility. While this duty may be accomplished by 'admissions clerks' at certain LTC facilities, specific job titles will be avoided in order to reach out to the participant sample of interest.

Long-Term Care Facility: A healthcare facility that provides a variety of services on a 24-hour basis to meet both the medical and non-medical needs of the residents. This type of facility is synonymous with nursing homes as it provides care to the older population with chronic illnesses or disabilities. Admission into a long-term care facility requires individuals to meet its strict eligibility criteria: be18 years or older, have a valid Ontario Health Insurance Program (OHIP) card, have 24-hour nursing care and personal care needs, have care needs that require on-site supervision/monitoring to ensure safety, and have care needs that cannot be safely met in the community through community-based services or other caregiving support.

Phenomenology: The philosophy of the human existence and people's perceptions and understanding of the world. Phenomenology was initially created to get at the universal essence of a phenomenon. This term later evolved into 'interpretive phenomenology' to state that although experiences may be descriptive in nature, their implantation is interpretive in the sense that a researcher is required to understand the data through identification of key thematic findings.

Social Phenomenology: A subtype of phenomenology that focuses on the impact of social relationships on the participants' daily life in order to achieve logical, adequate, and subjective meanings for findings.

Appendix B

Recruitment Letter

Date:

Dear Potential Participant,

I am contacting you in hopes of recruiting you for my research project titled, "Exploring the Lived Experiences of the Administrative Staff of a Long-Term Care Facility: A Phenomenological Approach". The central focus of this research project is to explore the perspective of the administrative staff working face-to-face with typically older persons and their family members/caregivers, with particular attention to the admissions process. As significant stakeholders on the phenomenon of admittance into LTC, this research project seeks to answer the central question of: What are the lived experiences of LTC administrators working with families/caregivers during the admissions process? This research project also hopes to identify any potential recommendations offered by the administrative staff on management of the admissions process/system.

If you are interested in participating in this research project, feel free to contact me at or via email at . Your involvement in this research project will be greatly appreciated as your experiences and perceptions will be crucial for furthering knowledge regarding this field of research. Thank you for your time and consideration.

Regards,
Rayka Sedaghat Modabberi

Appendix C

Interview Guide

Introduction

I would like to thank you for taking the time to meet me today. As previously mentioned, I am currently a graduate student at York University and am interested in studying the lived experiences of the administrative staff working with family members/caregivers and resident-to-be during the process of admission into long-term care homes.

This interview will last anywhere between 60 to 90 minutes and will be digitally recorded. I will also be taking some notes as the interview proceeds.

Before we start, I would appreciate it if you could read over and sign the informed consent form. It highlights your confidentiality and anonymity in the reports that I will be producing for my project. You may feel free to not discuss certain matters if you choose and may end this interview at any time without penalty.

Before we start, do you have any questions for me?

Questions

1) Can you tell me a little bit about yourself and how you came to work in this role and at this facility? [Probes: Duties/responsibilities? Full-time or part-time? Commute time to work?]
2) Can you tell me how the admissions process works at this LTC in terms of process/procedure? [Probes: When do you get involved in the process? How do families or caregivers or residents find you? When does your role in the admissions process end? Does the admissions system work in this LTC home – is it efficient, effective? How do the staff (administrative staff, nursing staff, other staff) work together – or not – during the admissions process]
3) Can you tell me a bit about what the move-in process for residents? [Probe: Are you involved in the actual move-in process? Do you follow up with family/caregivers re: move-in day? Do family members/caregivers follow-up with you once the resident is in? Is there a blurred line of duty in relation to the extent of your involvement with the resident-to-be and their family/caregivers?]
4) Without sharing personal or private information about the residents and/or their family/caregivers, do any specific admissions examples stick out for you and, if so, why?
5) Can you tell me a bit about your experiences working with residents-to-be and/or residents? [Probes: Positive or negative experiences? Why positive or negative? Any common patterns (e.g., common questions or concerns or stress points) in the exchanges between administrative staff and residents-to-be/residents?]
6) Can you tell me a bit about your experiences working with family members or caregivers? [Probes: Positive or negative experiences? Why positive or negative? Any common patterns (e.g., common questions or concerns or stress points) in the exchanges between administrative staff and family members/caregivers?]
7) Does working at the LTC home and/or working with family members/caregivers and residents make you think about your own health and healthcare, when now or in the future?

8) Without sharing personal or private information about the residents and/or their family/caregivers, has there been an instance in which the process of admission has left an impact on your private/daily life? [Probes: social interactions that lingered/affected your mood/activities?]
9) If you could change any part of the LTC system in the province, would you and, if so, what would you change, how would you change it and why? [Probe: Do you find it challenging or easy to address issues that arise that are within your scope of responsibilities? Examples?]
10) Are there any aspects of your job in which you have a lot of control over the admissions process? [Probes: How have you managed to better cope with the difficult components of the admissions process? Do you have any recommendations for improving the system? Do you have any recommendations for other administrative staff on how to cope with the difficult aspects of your job?]
11) Is there anything that you would like to add or clarify that has not already been covered?
12) Do you have any questions for me?

Closing Statement

I would like to thank you for your time today.

Once again, thank you participating in this interview. Feel free to contact me at any time if you have questions or would like to add anything after we leave today.

Appendix D

Informed Consent Form

Date:

Study Name: Exploring the Lived Experiences of the Administrative Staff of a Long-Term Care Facility: A Phenomenological Approach

Researcher name: Rayka Sedaghat Modabberi
MSc Student in Kinesiology and Health Sciences
York University

Purpose of the Research:

The purpose of this research project is to explore the lived experiences of the administrative staff working with the resident-to-be and their family members during the process of admission into a long-term care home facility.

What You Will Be Asked to Do in the Research:

The participant will be asked to engage in a 60 to 90 minute long interview session involving questions about their experiences with admitting residents into long-term care homes.

Risks and Discomforts:

We do not foresee any risks or discomfort from your participation in the research.

Benefits of the Research and Benefits to You:

There are no benefits to the research participants.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality:

Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any

report or publication of the research. Audio recording and the electronic transcription of data will be safely stored on the password protected computer of the interviewer. The recording will be immediately deleted from the computer upon completion of the transcription. Confidentiality will be maintained by making the data anonymous (for exmaple, using pseudonyms). The electronic copy of the transcription will be deleted from the computer of the interviewer by July 2021. The hard copy of data will be safely stored in the personal locked filing cabinet of the interviewer (located at their home). It too will be disposed of by July 2021 via a cross-cut shredder. Aside from the interviewr, Rayka Sedaghat Modabberi, the research supervisor, Dr. Parissa Safai, will have access to the collected information/data. Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me at or my supervisor, Dr. Parissa Safai at and/or . You may also contact the Graduate Program in Kinesiology and Health Sciences at and/or .

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone or e-mail).

Legal Rights and Signatures:

I_____, consent to participate in Exploring the Lived Experiences of the Family Members of Long-Term Care Home Residents: A Phenomenological Approach conducted by Rayka Sedaghat Modabberi. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature_____ **Date**_____
Participant

Signature_____ **Date**_____
Principal Investigator

Additional consent

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

Signature _____ **Date** _____

Participant Name:

Appendix E

TCPS Certificate


PANEL ON RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Rayka Sedaghat Modabberi

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **21 September, 2017**